Bexley Care Trust

2012-13 Annual Report and Accounts

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Bexley Care Trust

2012-13 Annual Report

Bexley NHS
Care Trust

Annual report 2012/13

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1. Welcome

Welcome to Bexley Care Trust's annual report for 2012/13. This is the final annual report to be published by the Care Trust, which along with all other PCTs in England ceases to exist after 31 March 2013. This change is a result of the reforms set out in the Health and Social Care Act 2012. In Bexley from 1 April 2013, the commissioning of healthcare will be the responsibility of NHS Bexley Clinical Commissioning Group, the NHS Commissioning Board, the London Borough of Bexley and Public Health England.

Throughout 2012/13 we worked to ensure NHS Bexley Clinical Commissioning Group (CCG) is the statutory body for health service commissioning in the borough from 1 April 2013.

By summer 2012, we saw the CCG receive delegated responsibility for its future areas of responsibility – hospital and emergency care, community health and mental health services. This was followed in March 2013 when NHS Bexley CCG was one of 46 emerging CCGs authorised by the NHS Commissioning Board in the final wave of the national process. However until April 2013, Bexley Care Trust remains the statutory body responsible for commissioning and our full board membership is listed on page x.

This has been an exciting and challenging year and we are proud of the work we have undertaken in Bexley to improve health and health services throughout a year of significant transition. Having clinical leaders at the helm of commissioning in Bexley is enabling us to focus on clinical outcomes for local people and to make decisions that are genuinely informed by local people and the clinicians that understand their needs so we can achieve the best possible health outcomes for Bexley residents. As this annual report shows, we are already seeing some significant success and hope to build on these in the year ahead.

We continue to develop our joint working with other boroughs and their Clinical Commissioning Groups. NHS Bexley CCG has undertaken programmes of service redesign in neuro-rehabilitation, diabetes and anticoagulation with Bromley and Greenwich CCGs. We have also secured a number of improvements across services such as planned care and community-based services as a result of working with the London Borough of Bexley.

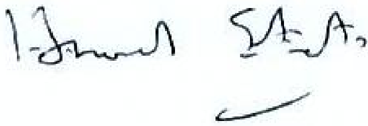
During the year, GPs, practice managers, practice nurses/nurse practitioners and key clinicians in Bexley have met to discuss issues focusing on how to work more efficiently and better integrate healthcare. In Bexley, we have held four engagement events for members to help them understand their new roles as commissioners from 1 April. Two events with key stakeholders such as the local authority, health providers, voluntary groups and patient groups have taken place to discuss the future of healthcare in the borough and our commissioning intentions for 2013/14 and beyond.

Financially, it has been a challenging year and the Care Trust has worked hard to ensure that statutory duties are met. In addition to the statutory breakeven duty the Care Trust is reporting a one per cent surplus of £3.5m, in line with its control total. We continue to address the challenges of the Quality, Innovation, Productivity and Prevention (QIPP) agenda. Providing a continued focus on this important area will be vital in ensuring financial sustainability as well as efficient, quality healthcare for Bexley's residents and across south east London.

Against a challenging backdrop, our staff have worked effectively with clinical leaders across the borough to achieve better outcomes for patients within the financial resources available to us. We believe this hard work and well established partnership has left the future clinical commissioning group well placed to deliver its vision for improved outcomes for the people of Bexley.

Andrew Kenworthy Chief Executive, NHS South East London (including Bexley Care Trust)

Caroline Hewitt, Chair, NHS South East London (including Bexley Care Trust)



Dr Howard Stoate, Chair, NHS Bexley Clinical Commissioning Group

Sarah Blow, Chief Officer (designate), NHS Bexley Clinical Commissioning Group

2. What we do

In 2012/13, Primary Care Trust's and Care Trust continued with grouping arrangements into 'clusters'. The aim of the clustering arrangements was to release savings in management costs for investing in front-line care, while maintaining the capacity for PCTs to carry out their statutory functions until they are abolished in April 2013.

NHS South East London is a partnership of Bromley, Greenwich, Lambeth, Lewisham and Southwark primary care trusts and Bexley Care Trust.

Bexley Care Trust has been delivering health and social care services for people in the borough since 2003. During 2012/13, it provided community health, public health and primary care services for Bexley's population of around 225,000. It also commissioned services from a range of local and specialist hospitals, the independent sector and the voluntary sector.

It worked in close partnership with many other local organisations including Oxleas NHS Foundation Trust, South London Healthcare NHS Trust, the London Borough of Bexley, the Trust Special Administrator, community groups and the voluntary and independent sectors.

Bexley Care Trust is responsible for ensuring that people receive the best healthcare possible and that they have a say in how local health services are delivered.

2.1 Strategies for improving health in the borough

Bexley Care Trust is responsible for improving health and wellbeing for the people who live, work or visit Bexley. The organisation assesses local healthcare needs and arranges and

pays for the healthcare services needed to meet those needs ('commissioning'). During 2012/13 the Bexley Care Trust Board has been supported by the Bexley Clinical Commissioning Committee, a group of local primary care clinicians who are taking on the work of commissioning to improve the health of Bexley people and to enhance the quality of local health services.

Working with partners in the local NHS (GPs, pharmacists, dentists, opticians, hospital and mental health providers), with other borough partners (such as the London Borough of Bexley and local voluntary and community groups) and with local people and patients, Bexley Care Trust seeks to improve health and wellbeing and reduce health inequalities, ensuring everyone has equal access to the highest quality healthcare services.

Bexley Care Trust offers the people of Bexley a wide range of services to help them stay healthy and to care for them when they fall ill and need extra support. The Trust aims to deliver high-quality services, providing communities with the right care, at the right time, in the right place and that are easy for people to use.

In 2012/13 we spent more than £369 million to commission health services, using funds Bexley Care Trust receives from the Department of Health. This report will demonstrate how money has been spent on behalf of Bexley's communities.

The vast majority of people using the NHS in Bexley will use primary and community health services. These services are commissioned from:

- GPs, pharmacists, opticians and dentists
- Community health services such, as district and school nursing, health visiting, specialist child health, therapy services and care for older people, provided through Guy's and St Thomas' Foundation Trust
- Voluntary and third sector care providers

When people require more specialist care, the following services are also commissioned:

- Guy's and St Thomas' NHS Foundation Trust, Kings Healthcare NHS Foundation Trust and St George's NHS Trust to provide inpatient, outpatient, day and emergency care
- South London and Maudsley NHS Foundation Trust to provide mental health and addictions services

The commissioning of specialist services is undertaken by London Specialised Commissioning Group. The services commissioned include bone marrow transplants, renal dialysis, haemophilia, neonatal intensive care (NICU), and specialist care baby units (SCBU). During 2012/13, additional services were transferred to the remit of specialised commissioning and these included child and adolescent mental health services (CAMHS), eating disorders, forensic mental health services and paediatric oncology. Bexley Care Trust had a budget of £15,612k in 2012/13 in respect of specialised commissioning and the out-turn position for these services was an underspend of £685k.

2.2 Achievements

Bexley a health hub at Queen Mary's Hospital

Bexley Care Trust has been working with its partners to continue its plans to develop a health 'hub' at the Queen Mary's hospital site in Sidcup.

In July 2012/13, a Trust Special Administrator (TSA) was appointed by the Secretary of State for Health, to make recommendations about the future of health services at South London Healthcare NHS Trust and wider south-east London.

Bexley Care Trust and the local authority were engaged in the TSA's consultation processes, to ensure the health and social care needs of patients in the borough were acknowledged and understood.

On 31 January, the Secretary of State for Health, Jeremy Hunt, announced his decision on South London Healthcare NHS Trust and the NHS in south-east London, having reviewed the TSA's final report. This included a recommendation to develop a 'hub' at Queen Mary's Hospital in Sidcup.

Bexley Care Trust has been working to ensure these plans are developed, which will feed into the transformational work that needs to be undertaken in 2013/14.

For more information about Bexley Care Trust and the Trust Special Administrator process, please see page 13.

Diabetes service delivering the best results in London

There have been a number of successes as a result of improved diabetes services in recent years and this momentum has continued into 2012/13, to address the higher rate of diabetic patients diagnosed compared to the UK average.

Improved diabetes statistics are largely attributed to the way in which services have been redesigned to the needs of patients. Some of these developments include:

- Launching a project to target patients at risk of developing diabetes
- Increasing the number of structured education programmes, to ensure patients can attend – as a result, more than 1,000 patients have attended
- Delivering the UK's largest average reduction in HbA1c of 15.5% to 7.1% as a result of patients attending the structured education programme
- Launching two new groups with young people and seldom heard communities to ensure the patient's voice is central and directly involved in design and delivery
- Halving secondary care referrals by moving care into the community

Changes to the way in which some diabetes services are provided were developed with practices and key stakeholders in early 2013, to move more care into a primary care setting. More than 40 patients and those with an interest in diabetes attended an engagement event in February, to learn how their comments had shaped the changes to services, as well as discuss a diabetes model for Bexley, Bromley and Greenwich moving forward.

In March, GPs, practice nurses/nurse practitioners and practice managers attended an engagement session to learn more about the changes to diabetes, in particular the Locally Enhanced Service (LES).

Increased savings through Bexley's award winning cardiology scheme

Bexley's award winning Primary Care Chest Pain Clinic – which sees patients travel from the borough to Harley Street for world-class cardiology care – has continued to deliver improved patient outcomes and cost savings in 2012/13.

To date, the scheme designed and run by local GPs and a top cardiologist, has accumulated savings of £1.3million. The clinic also produces 100% accurate test results, saving lives while

preventing unnecessary suffering, at less cost than traditional care pathways. Patient evaluation shows 100% satisfaction.

Working with the local authority to improve prevention and support in patient's home and in the community

Bexley Care Trust has been working with the local authority to develop an integrated health and social care system, which provides high-value care for residents in Bexley.

The programme will provide a planned approach to complex care, enabling residents to be more independent for as long as possible at home, reducing the need for unplanned hospital admissions or long-term care.

The integrated care programme seeks to change the way in which professionals engage with each other across acute, community and social care, to provide a better experience for patients. Some of the programmes of work, aiming to deliver improvements include:

- Improving the coordination of services (case management)
- Introducing a community geriatrician service
- Redesigning intermediate care services (Step-Up Step-down)
- Adopting an integrated model joining-up multi-disciplinary and community rehabilitation services
- Introducing integrated rapid response and assessment/discharge teams

It is hoped that the integrated approach to redesigning services, will improve productivity and the quality of care for patients and avoid admissions to care homes and hospitals.

Procuring community stroke and rehabilitation services

In 2012/13, Bexley Care Trust started a procurement process for community stroke and rehabilitation services. The new service will improve patient outcomes and raise quality.

The procurement of the new services meant the Elmstead Unit – which provides rehabilitation services to residents with Multiple Sclerosis, spinal cord injuries, Guillain Barre Syndrome, Cerebral Palsy, Ataxias and Muscular Dystrophy – was decommissioned.

The new services, which will meet the needs and requirements all patients needing rehabilitation services, are expected to be in place by July 2013.

Joint Commissioning Unit established

In 2012/13, together with the local authority, Bexley Care Trust established a Joint Commissioning Unit. The programme provides both organisations with:

- The ability to take an integrated approach to commissioning services for people who have both health and social care needs
- The ability to get the best value for money, by sharing resources between both organisations

The development of the Joint Commissioning Unit alongside the Joint Strategic Needs Assessment (JSNA), enabled Bexley to develop a robust health and wellbeing strategy.

Successful engagement with stakeholders on commissioning intentions for 2013/14 and beyond

In 2012/13, Bexley engaged with patients, GPs and key stakeholders on the development of its commissioning intentions as part of succession planning for the emerging organisation taking on commissioning responsibilities from 1 April onwards.

More than 240 people attended the two engagement events, providing specialist advice and input, to help the emerging Clinical Commissioning Group strengthen its plans. This communication, in the form of events, online forms, emails and newsletter updates has received positive feedback and will continue by the successor organisation in 2013/14.

Bexley Stop Smoking team win national award

In November 2012, Bexley Care Trust's Stop Smoking Service won a national award for its impromptu flash mob dance, promoting the service in Bexley town centre.

The team won first prize in the 'most unusual/innovative event' category at the British Heart Foundation's 2012 Organiser of the Year Awards.

The flash mob of students from Bird College in Sidcup, surprised hundreds of shoppers with their routine and enabled the stop smoking team to engage and promote quitter services.

Bexley's Stop Smoking Service was tasked with helping 1,600 people in Bexley 2012/13 to quit smoking.

Bexley GPs pilot HIV testing

In August, Bexley Care Trust launched a HIV testing pilot in primary care, in response to news that the number of people living with the condition increased by 89% (2 per 1.000 prevalence rate) in the last five years.

The six-month pilot initially focused in the north of the borough, with GP practices in Belvedere, Erith, North End, Slade Green and Thamesmead East invited to take part.

Routine testing is now available to new patients aged 15-59 at registration, at risk groups, patients with possible HIV-related symptoms and individuals requesting a test.

The findings of the pilot will be considered by local commissioners and the local authority in 2013.

2.3 Risk management – how risk is managed in south-east London?

The NHS South East London approach to risk management and board assurance is in accordance with legislation and national and local guidance. It seeks to embed recognised and developed best practice through a process of on-going review and improvement while underpinning the production of the Annual Governance Statement. NHS South East London has comprehensive governance and risk management strategies ensuring corporate and key objectives are met. Full details of the NHS South East London approach to risk management can be found in the final accounts and annual governance statement.

3. Health and wellbeing in Bexley

Bexley is a borough of contrasts with 21 wards, some of relative affluence and some with significant deprivation. Its younger population has particular needs such as those associated with rising levels of obesity. It has a growing older population, with attendant issues of chronic disease, such as diabetes and cardiovascular disease.

To meet the contrasting health needs of the local population, Bexley Care Trust provided services in three localities: Clocktower, North Bexley and Frognal, with around 75,000 people in each.

Bexley Care Trust continues to work closely with the London Borough of Bexley, for example, in public health and the Joint Strategic Needs Assessment (JSNA). Overseeing developments is the Health and Wellbeing Board, which continues to develop joint commissioning processes, along with the transition of public health into the local authority. It also makes recommendations on areas of service redesign.

Understanding the needs of the population

To get the most accurate picture of Bexley's population, Bexley Care Trust, in partnership with the London Borough of Bexley, produce a Joint Strategic Needs Assessment (JSNA), which is refreshed annually. The JSNA draws together the latest surveys, local consultations and statistics and is at the centre of all decisions made about health services in Bexley.

An aging population: Projections up to 2016 indicate an increasing proportion of residents over 65, with a corresponding decrease in those aged 15-64. Approximately 15 per cent of the population of Bexley are over 65 compared to the London average of 12 per cent. It means a rising need for services for diseases linked to ageing such as heart disease, diabetes and cancer.

Ethnicity: Bexley is becoming more ethnically diverse. There is a correlation between ethnic minority populations in Bexley and areas of deprivation.

Deprivation and ill-health: In each of the three localities, there are pockets of deprivation, which has a direct impact on general health and life expectancy. Average life expectancy in Bexley is lower for men at 79 years and women 84, compared to the England average overall. Residents in areas of higher deprivation live an average six years less than those in more affluent areas.

Births: The number of births in Bexley is predicted to rise by two per cent by 2016, with the largest percentage in black and other ethnic minority communities. Infant mortality is falling in Bexley, as is the incidence of low birth weights.

Main causes of admission to hospital: Cancers, dementia, respiratory conditions are the main causes of hospital admissions.

Health and wellbeing: Obesity continues to be a concern with 10.7 per cent of reception aged children being identified as clinically obese rising to 22.2 per cent in year six. Just over 19 per cent of adults in Bexley smoke and the take-up of physical activity is low for children and adults. As a result, diabetes, heart disease, strokes and cancer are set to increase, particularly in populations of higher deprivation.

The National Child Measurement Programme (NCMP) found that in 2011/12, 25 per cent of reception class children and 37.5 per cent of year six children in Bexley were either overweight or obese. These figures are higher than the English average of 22.6 per cent for reception class and 33.9 per cent for year six. In Bexley, the percentage of children in year six who are obese is nearly twice that for reception year.

In 2012/13, Bexley Care Trust invested resources to help tackle childhood obesity by delivering a weight management programme for children and their families. This included a number of courses and summer clubs. More than 60 children attended the summer clubs

alone, to help them and their families learn more about healthier balanced diets and to take part in various sports and activities.

The health and wellbeing board have agreed childhood and adult obesity as one of their five joint priorities for 2013/14.

4. Commissioning healthcare

As part of the Health and Social Care Act, Primary Care Trusts and Care Trusts, will be abolished on 31 March 2013. The commissioning of most healthcare in the borough, will the responsibility of clinical commissioning groups (CCGs). Clinical commissioning in Bexley has been led by Bexley Clinical Commissioning Group, engaging all 28 practices. With local practitioners engaged in the practice-based commissioning initiative since 2005, GPs in Bexley are well placed to take on this new role from 1 April 2013.

NHS Bexley Clinical Commissioning Group has had delegated responsibility for overseeing the commissioning of most healthcare services since April 2012. However, Bexley Care Trust remains the statutory organisation until 31 March 2013. Clinical members of the CCG's governing body are elected by GPs. Governing body meetings are held in public and details are available at www.bexley.nhs.uk.

Bexley Care Trust's main priorities for commissioning services were detailed in its 2012/13 integrated plan. This included:

- Choice – giving patients more power, choice and information to prevent disease and illness
- Staying healthy – supporting residents, through wellness education and prevention programmes, to manage their health and wellbeing in collaboration with the London Borough of Bexley
- Out of hospital care – providing care in the community where safe and appropriate
- Unscheduled care – seeking to divert, non-complex treatment where possible to primary and community settings
- High-quality, integrated care – improving the quality and continuity of local community health and social care providers
- Development of the clinical commissioning group – accelerating the development of the capacity and capability of the clinical commissioning group, to ensure it is able to take on commissioning responsibilities by April 2013

4. Improving quality and performance

Setting the strategic direction for Bexley Care Trust

A number of key documents guided the activity of Bexley Care Trust in 2012/13:

The **Joint Strategic Needs Assessment (JSNA)** was refreshed in 2012/13 by the Care Trust, London Borough of Bexley and wider partners. The JSNA informs the borough's strategic direction. It brings together a wealth of information on the health and wellbeing of the communities which make up Bexley.

In 2012/13, Bexley published the **integrated plan**, which sets out the emerging organisations vision and the vision for constituent membership of GP practices. The plan also sets out the vision and strategy for the next three years and provides a detailed plan for the 2012/13 financial year. The plan takes into account the authorisation process for NHS Bexley Clinical Commissioning Group, who will take on commissioning responsibilities from 1 April 2013.

The **operating plan** describes how the Care Trust in partnership with other local organisations will deliver the health outcomes required, while continuing to balance its books.

In 2012/13 Bexley Care Trust developed its **commissioning intentions** to improve quality and performance. Key stakeholders, including patients, patient interest groups, clinicians, providers, voluntary groups/organisations and the local authority, were able to feed into this process by attending events or submitting their feedback directly to the care trust.

This engagement was also used to develop the commissioning intentions for the emerging Clinical Commissioning Group, who would be responsible for the commissioning of most healthcare services in the borough from 1 April 2013. More than 240 people attended the two engagement events in October 2012, providing specialist advice and input, to help the CCG strengthen its plans.

5. Working in partnership

London Borough of Bexley

Bexley Care Trust has been working closely with the local authority on a number of initiatives and service redesign pathways. A transition group was established to oversee the transfer of public health staff to the local authority. The team were successfully co-located in 2012 and will be fully integrated by 1 April 2013.

In 2012/13 Bexley Care Trust and the London Borough of Bexley refreshed the Joint Strategic Needs Assessment (JSNA) and progressed the Joint Commissioning Board and the Health and Wellbeing Board deciding five joint priorities for 2013/14.

Clinicians and mangers have been working together to improve safeguarding services by joining safeguarding improvements boards and agreeing to establish a Multi-Agency Safeguarding Hub (MASH).

Key strategies have also been developed such as the Joint Strategic Needs Assessment, intermediate care pathways and the carer's strategy.

Bexley Care Trust and the London Borough of Bexley also agreed and developed a joint commissioning structure. This structure includes an assistant director for the integrated service and a head of commissioning for children and young people, adults and older people. With more care being provided in the community, the integrated approach to commissioning will ensure that services for older people, adults, children and young people are more efficient and deliver better patient outcomes.

Overview and Scrutiny Committees

The Overview and Scrutiny Committees investigate local issues and make recommendations to improve services to residents in the borough. In addition to overseeing council services, the committees are responsible for looking into health service issues and crime and disorder.

Bexley Care Trust and the emerging organisation, NHS Bexley Clinical Commissioning Group, were both represented at the Health Overview and Scrutiny Committee in 2012/13, to discuss issues such as:

- Changes to services such as diabetes
- National updates and the impact at a local level
- Trust Special Administrator updates

Bexley, Bromley and Greenwich

In 2012/13 Bexley Care Trust invested resources to develop collaborative working with Bromley and Greenwich and the shared health economy. An anticoagulation procurement was undertaken and diabetes services were developed across the three boroughs.

Standards of care have been improved by developing and implementing Bexley, Bromley and Greenwich pathways for cardiology, musculoskeletal and neuro-rehabiliation.

South-east London

Bexley Care Trust has been working in partnership with its partners across south-east London on:

- The Trust Special Administrator programme to help shape local healthcare across the six boroughs and beyond
- The development of the Commissioning Support Unit, which will provide support services to Clinical Commissioning Group from 1 April 2013
- Establishing an area prescribing committee to help commissioners and hospitals across the six boroughs to work collaboratively, ensuring there is a consistent approach to making the best use of medication, advising on best practice and allowing clinicians to take a broader approach in prioritising and developing healthcare in relation to medicines.
- Joint commissioning in areas such as bariatric surgery, cancer and stroke networks
- Developing a Programme Management Office (PMO) to enhance the way commissioners work together by co-ordinating common healthcare improvement programmes, enable sharing of best practice and link local work to London-wide and national programmes.

National Commissioning Board (NCB)

Bexley Care Trust has been working with the NCB on a number of transitional programme areas. For example, collaboration with the NCB to improve quality in primary care, which will enable practices to agree development plans, to improve areas of weakness in relation to quality, access and performance.

Trust Special Administrator

When the Trust Special Administrator (TSA), Matthew Kershaw, was appointed by the Secretary of State for Health in July 2012, Bexley Care Trust, along with its partners in south-east London and Kent, was and continues to be engaged in the changes to healthcare.

Having engaged with GPs, patients and stakeholders, NHS Bexley Clinical Commissioning Group submitted a response to the consultation process.

Bexley Care Trust's proposal to develop a 'hub' on the Queen Mary's Hospital site was included in the TSA's recommendations. Commissioners and providers are now considering service model plans and establishing how the necessary changes can be best taken forward.

During the summer and autumn 2012, commissioners from across the six south-east London boroughs, worked together to identify their aspirations for community-based care. The community-based care plans were made available to the TSA to use when planning the future

of acute hospital configuration and capacity. A draft strategy was included in the suite of documents issued by the TSA for consultation at the end of October 2012. During this time, the south-east London commissioners, the National Commissioning Board authority regional office for London, local authorities, local education and training boards worked together to implement the strategy.

Bexley patients and residents

Bexley Care Trust has continued to support the Bexley Patient Council in 2012/13 to ensure patients; the public and other stakeholders have significant influence in how the organisation develops and commissions services. Throughout the year, the group have made a number of valuable contributions such as, providing feedback on the standard of commissioned transport services and feeding into the procurement of services.

The chair of the patient council is elected by its members every two years and sits on NHS Bexley Clinical Commissioning Group's (CCG) governing body. NHS Bexley CCG is the organisation that takes on commissioning healthcare in the borough post 1 April 2013.

Bexley Care Trust has continued to provide GP practices with support to establish or continue Patient Participation Groups (PPGs). More than 80 per cent of practices have a PPG.

The Care Trust continues to build strong networks and engages on a regular basis with identified protected groups. Representatives from Bexley Care Trust regularly attend community forum meetings and engage with local residents to share information about local healthcare. Other community engagement throughout 2012/13 has included:

- Targeted engagement with seldom heard groups
- Mystery shopper sessions
- Intergenerational project
- Young people's engagement – health jury, youth parliament
- Older people's engagement – celebrating older people's day, pensioners forum
- Presentations and attendance at community and voluntary sector forums and groups
- Attending events, annual general meetings, forums and consultations

Responding to complaints

Complaints together with concerns, comments and compliments provide an important source of information about the quality of service both provided and commissioned in Bexley.

Bexley Care Trust aims to provide the best possible care for people who use NHS services, their families and carers. There may be times when an individual is not satisfied with the service they receive and may wish to raise a concern or complaint and Bexley Care Trust offers a choice on how to do this. Patients may wish to speak to the staff supporting them, or to the local manager of the service. If the patient feels unable to do this, they can contact Patient Advice and Liaison Service (PALS) to receive an informal response to their concern or complaint. Alternatively, the patient may wish to make a formal complaint.

Whether a concern or complaint is responded to via PALS or the formal complaints procedure, the individual will receive either a verbal or written explanation of what happened, an apology (if appropriate) and an explanation of what Bexley Care Trust will do to try and resolve the issue.

During the period 1 April 2012 to 31 March 2013 Bexley Care Trust received 64 formal complaints (31 per cent decrease from the previous year), this included 29 directly received complaints relating to independent contractor services such as GP practices, dental surgeries

and community pharmacists. In addition, Bexley Care Trust was asked to investigate 22 complaints relating to acute/hospital services. Two complaints related to mental and community health services. The remaining 11 complaints were raised in relation to commissioning decisions. The Parliamentary and Health Service Ombudsman (PHSO) asked Bexley Care Trust to review two complaints.

Bexley Care Trust is committed to learning lessons from feedback received and ensures complaints are used as a tool for service improvement. A number of cases received last year prompted service reviews and the development of improvement action plans. This is achieved by working with staff and by reporting identifiable trends through the clinical governance process and reports to the quality and safety working group.

Patient Advice and Liaison Service (PALS)

PALS provides an impartial and confidential service offering information, advice and help with accessing and using health services. Through PALS enquiries, Bexley Care Trust is able to review and respond to issues directly, as well as identify patterns of comments or concerns that can be used to help inform service improvements. The service provides a single point of access for patients, their relatives and staff and can help with all enquiries – listening, offering advice and information, signposting and problem solving. In 2012/13 PALS dealt with more than 2,321 contacts.

It is important to Bexley Care Trust that people feedback their thoughts, comments and concerns regarding all aspects of the health services that are provided. All comments are valued and help Bexley Care Trust to respond to the needs of residents living in the borough.

6. Making it happen

Introduction

NHS South East London currently employs 753.45 full-time equivalent (FTE) staff across five Primary Care Trust's and one Care Trust. Following the last organisational change process in March 2011, which led to the creation of NHS South East London, a new human resources team was formed. Staff in Bexley receive HR expertise, advice and support from this central team together with workforce transformation support as the organisation continues to develop its services towards delivering GP commissioning.

NHS staff survey

Primary Care Trust's and Care Trusts were not required to undertake the 2012 staff survey due to the announcement of the abolishment of Primary Care Trust's.

Sickness absence

Monthly sickness absence reports include individual sickness absence trends. These are discussed with appropriate managers to ensure that the right support is provided to staff who are absent due to sickness to enable appropriate and timely returns to work.

The sickness absence rate for the NHS in England for the period July to September 2012 was 4.06 per cent.

The following sickness information relating to Bexley care Trust has been provided by Department of Health ESR system:

	2012-13 Number	2011-12 Number
Total Days Lost	**467**	**433**
Total Staff Years	**77**	**95**
Average working Days Lost	6.05	4.56

Training and development

The NHS South East London Staff Development Programme was launched in September 2011 based on the training needs identified in personal development plans. This programme offers a range of learning and development opportunities for staff such as project management with the aim of supporting knowledge, skills and personal development particularly during a period of organisational change. The programme also ensures that all staff work in a safe and effective way and are up to date with their statutory and mandatory training. Staff can also apply for external training that is not covered by the programme.

- Six different training courses were offered to staff up to March 2013, arranged in seven course sessions with a total of 85 places available
- 47 staff have had individual training fund requests approved.

Additionally, in March 2012, NHS South East London launched the 'Piecing Together Change' programme designed specifically to help support staff during transition. The programme comprised 85 workshops with a total of 1,020 places available. The second part of the programme comprised of a series of one-to-one clinics providing additional support to staff affected by change. A total of 126 slots of 1hour 15 minutes were made available to staff.

Equalities action plan for NHS South East London staff and leadership

As part of the development of the NHS South East London equality objectives for 2012/13, the HR team developed equality objectives for the staff and leadership of NHS South East London. The purpose of setting these objectives is to strengthen performance under the Public Sector Equality Duty (PSED) of the Equality Act 2010. The development of the equality objectives has been aligned to the outcome of Equality Delivery System (EDS) grading for staff and leadership, the EDS goals and outcomes, and priorities for people transition. The EDS grading for the staff and leadership of NHS South East London was carried out at the beginning of March 2012.

To comply with statutory duties to publish workforce information on the nine protected characteristics in the Equality Act 2010, NHS South East London recently carried out a process of data cleansing of personal information held on the HR Electronic Staff Record (ESR) system.

This process has enabled the organisation to collect non-personalised data to provide an initial equality and diversity baseline across the six PCTs. This indicates the coverage of information collection across the protected characteristics: age, disability, gender reassignment, marriage and civil partnership, race, religion and belief, sexual orientation, ethnicity, and pregnancy and maternity. The data collection process was completed again in early 2012/13 to improve the accuracy and completeness of personal information held on the HR information system. This will be used to form the baseline for equality impact assessments to ensure a fair and consistent transition process for all staff.

Emergency preparedness, resilience and response

Emergency planning and response has been coordinated by NHS South East London at a cluster level with participation of Bexley Care Trust emergency planning leads through a

combined steering group. This group formed policies and plans and ensured that the PCTs remained resilient through transition and this was evidenced in an assurance process conducted by NHS London in 2012.

In 2012 contingency and emergency plans were drawn-up as part of the London Olympic and Paralympic Games. A high-level senior coordinating committee planned and coordinated all providers, from the major acute trusts to small community pharmacies and nursing homes, to ensure everyone was prepared. The Cluster also worked closely with local authorities and Transport for London to ensure that staff and service users were aware of the possible impacts of the Games and disruption was kept to a minimum.

Bexley Care Trust's emergency preparedness, resilience and response functions will transfer to either the NHS Commissioning Board (who will undertake the majority of emergency planning and response functions for London) or Public Health England (who will be responsible for the local and regional health protection) in liaison with directors of public health who will be integrated with their local authority.

Clinical Commissioning Groups (CCGs) will continue to play an important role in emergency preparedness, resilience and response, with responsibilities under the Civil Contingencies Act and a focus on ensuring that South East London's health service remains robust in planning for, and managing surges in demand. They will also be required to assist the Commissioning Board in the event of a major incident. CCGs will additionally be represented on their local borough resilience forum and the strategic body, the London Local Health Resilience Partnership.

A transition process has been underway since 2012 to ensure that these functions are handed over safely with assurance exercises conducted in 2013, prior to the handover culminating in Exercise Sentinel, which took place in early February. The NHS Commissioning Board South Area emergency preparedness, resilience and response team will continue to work with all CCGs, providers and stakeholders in South East London to ensure that the NHS remains resilient in planning and response in the years to come.

Communicating with our staff

This year has been one of huge change and uncertainty for Bexley Care Trust staff, with Primary Care Trusts being abolished from 31 March and Clinical Commissioning Groups emerging.

In Bexley, communicating with staff has always been a priority, particularly during periods of uncertainty. Good communication is vital to the effective implementation of organisational change and a number of systems were put in place, to provide clear and consistent information to staff and enable them to contribute and engage in developments. These include:

- Regular updates through the fortnightly staff newsletter – Bexley Bulletin
- Circulating the fortnightly NHS South East London cluster update
- Monthly staff briefings with the managing director to enable staff to ask questions and feedback
- 'Lunch and learn' sessions
- Updated databases to ensure all staff are included in regular communications
- Dedicated areas on the Bexley Care Trust intranet to keep staff and GPs up to date with regular developments
- Links to the NHS South East London intranet and website
- Video messages from NHS South East London chief executive on key policy areas uploaded onto the staff intranet

- Confidential comment box and email addresses for questions raised and responded to.

As part of Bexley Care Trust's commitment to effective and productive conduct of employee relations, the organisation is part of a cluster-wide joint partnership forum with staff side representatives. The purpose of the forum is to identify and facilitate workforce and employment business. This involves negotiation and consultation on policies and impending organisational changes. The forum meets every other month and is committed to continuously improving the working lives, health and wellbeing of staff.

During the last year, Bexley Care Trust has also worked collaboratively with other PCT's across London on communication campaigns and initiatives. This has enabled Bexley Care Trust to benefit from shared expertise and consistent public messaging around key organisational priorities. This includes a:

- London-wide flu campaign encouraging people at risk to get vaccinated
- South-east London Choose Well campaign based on patient insight and evaluation
- Bowel cancer awareness campaign
- Medicine's waste campaign

Effective communications will remain an important component of successfully moving to the new commissioning healthcare system in 2013.

Equal opportunity for all

The Equality Delivery System (EDS) aims to achieve positive cultural change in the NHS by creating an environment where services for patients and workplaces for staff are more equitable, diverse and that fairly represent the wider community. The Corporate Equalities Group, set up to implement the EDS across NHS organisations in South East London.

The EDS enabled Bexley Care Trust to meet the aims of the Equality Act 2010, which is a legal requirement of all public organisations to take the necessary actions to achieve:

- Elimination of unlawful discrimination
- Advancement of equality of opportunity
- Fostering of good relations between individuals and communities

Adoption of the EDS was an essential requirement in order for the new Clinical Commissioning Groups (CCGs) to become authorised. After adopting the EDS in 2011, Bexley Care Trust developed a strategy in 2011/12 to meet its objectives and shared this with our stakeholders. During 2012/13 Bexley Care Trust continued to build on its achievements and made significant progress against these objectives and actions identified during 2011/12. In January 2013, the progress made against the set objectives was published. In March 2013, engagement with stakeholders took place to present evidence and progress made and undertaking a re-grading exercise. This grading will be publicised on the Bexley Care Trust and NHS South East London public websites.

Achievements during 2012/13 include:

- Equality embedded into the new CCG organisations
- Joint Strategic Needs Assessments cover all the protected characteristics and key disadvantaged groups
- Cluster-wide performance in the Learning Disability – Self Assessment Framework (LD-SAF) 2012 improved significantly, with central co-ordination and monitoring
- All local NHS organisations complied with the Public Sector Equality Duty (PSED)

- CCGs have equality leads at non-executive and executive levels and/or they have purchased an Equality and Diversity Service from the South London Commissioning Support Unit

The efforts of staff at many levels in the NHS organisations, in implementing the EDS have played a part in improving health outcomes for all and reducing health inequalities across south-east London.

For more information, visit http://www.selondon.nhs.uk/about_us/equality_and_diversity.

Serious incidents

A serious incident is something out of the ordinary or unexpected, with the potential to cause serious harm, and/or likely to attract public and media interest that occurs on NHS premises or in the provision of an NHS or a commissioned service.

In 2012/13, there were two serious untoward incidents reported in Bexley.

Estates

2012/13 has been a year of capital investment in the Bexley community estate, in order to reduce backlog maintenance and to cut CO_2 output. Work has included significant refurbishment of Bexley CCG's chosen HQ site at Erith Road. Financial and technical support has provided improvements to GP practices prior to their registration with the CQC by 1 April 2013.

Station Approach has been vacated in readiness for disposal in 2013 and the Bedensfield building has been demolished.

Support has been provided to primary care including on-going rent reviews and the development of a new primary care facility in Crayford.

Considerable time has been given to the Department of Health completing due diligence returns in support of the transfer of the estate planned for 31 March 2013 to community service providers, Partnerships for Health or to NHS Property Services Ltd. Additional resources have been made available to progress where possible, outstanding TSC and other tenant leases prior to transfer.

Oxleas have retendered the Hard FM and Soft FM contracts resulting in substantial cost savings.

Information governance

In March 2012, Bexley Care Trust completed its annual self-assessment of the information governance toolkit, achieving a satisfactory level two rating in all its information governance requirements. Achieving a minimum of a level two is now a mandated requirement of all NHS organisations. This also meant that the care trust successfully met the information governance statement of compliance for 2012/13.

All Bexley GP practices also completed their information governance toolkits in the target date and achieved a level two score meeting the minimum requirement set.

The mandatory IG training target for 2012/13 changed for all organisations achieving 95 per cent to 100 per cent achievement of mandatory IG training for all staff and contractors. One

hundred per cent of Bexley staff completed the information governance training prior to the 31 March deadline.

The 2012/13 information governance toolkit submission will be the last for Bexley Care Trust. From 1 April 2013, Clinical Commissioning Groups will undertake the toolkit.

Protecting your information

To provide the best possible healthcare services, NHS organisations collect sensitive and/or confidential information, often called Personal Identifiable Data (PID). Information governance set standards to ensure information is dealt with legally, securely, efficiently and effectively.

Throughout this year, the trust has focused on the management and preparation of change in the NHS to ensure continuity of service and appropriate controls around patient information. All staff have to undertake information governance training and the trust continues to be committed to the standards set out by the Care Record Guarantee and the information governance toolkit.

The trust continues to ensure the security of patient information is protected and maintain appropriate access. The trust is reviewing current ways of working as well as supporting new innovations ensuring appropriate controls and security is in place.

Areas of focus during 2012/13:

- Records management in transition for public health and PCTs in response to the NHS London guidance published from October 2012
- Information security – ensuring that patient information continues to be handled safely and securely
- Registration Authority – ensuring there is an appropriate framework in place that meets NHS and legal requirements to provide, monitor and manage access to NHS Care Record Service systems such as GP clinical systems

Sustainability

The health of people in Bexley is directly affected by the environment and therefore, the Trust continued to be committed to acting in an environmentally responsible manner in discharging its statutory duties. The Trust recognised the requirement to have a robust green/environmental policy in place, which shows its commitment to wider/global issues involved.

In 2012/13, the Trust continued to implement a range of 'green initiatives' such as:

- Maintaining a battery collection point
- Adhering to a green action plan
- Utilising recycling bins and desk paper trays
- Ensuring all business case documents and reports consider green/carbon reduction
- Removed a number of photocopiers in the building to reduce paper waste

7. Governance

The Board

On 1 April 2011, NHS South East London was established as a transitional organisation to take us through to 2013 and the implementation of the new healthcare system. NHS South East London consists of a single shared corporate management team and six borough-based business support units (BSUs). There is a single accountable officer (the Chief Executive), an

executive team made up of the Chief Executive and four other directors (three from 1 June 2012), a chief nurse and a medical director who work with the managing directors of the six BSUs and the Chairs of the Local Clinical Commissioning Committees.

The joint boards are six individual PCT/care trust boards that work together as one entity, undertaking the duties that are enshrined in law relating to the governance of primary care trusts and care trusts, but fulfilling them in a slightly different way. Certain mandatory positions on the boards, such as the chair and chief executive, are fulfilled by the same individual across all of the boards, while other positions are taken by local BSU managing directors and locally focused non-executive directors. Fulfilling the same legal duties as trust boards have always had, the boards focus on developing strategies and priorities for the entirety of South East London, ensuring that the shadow clinical commissioning groups are fulfilling their duties, in accordance with what is delegated to them.

Throughout 2012/13 the boards met every two months, in public. All meetings were quorate for all boards. During 2012/13, the Bexley Care Trust Board members were as follows:

Name	**Position**
Caroline Hewitt	Chair, NHS South East London
Steven Corbishley	Non-Executive Director
Andrew Kenworthy	Chief Executive NHS South East London (undertook a secondment from 4 September 2011)[1]
Christine Craig	Interim Chief Executive NHS South East London (from 3 September)
Richard Chapman	Acting Director of Finance[2]
Malcolm Dennett	Interim Director of Finance (from 14 November 2012)
Alison Tonge	Interim Director of Finance (from 6 August 2012 – 15 November 2012)
Jane Schofield	Director of Operations and Joint Deputy Chief Executive
Gill Galliano	Director of Development and Joint Deputy Chief Executive (until 30 July 2012)
Donna Kinnair	Director of Nursing (undertook secondment from 1 October 2012)
Jane Clegg	Interim Director of Nursing (from 1 October 2012)
Susan Free	Non-Executive Director
Harvey Guntrip	Non-Executive Director
Keith Wood	Non-Executive Director
Paul Cutler	Non-Executive Director
Cllr John Davey	Bexley Council Appointment
Cllr Eileen Pallen	Bexley Council Appointment
Dr Howard Stoate	Chair, Bexley Clinical Commissioning Group
Sarah Blow	Managing Director, Bexley Business Support Unit (from 8 October 2012)
Pamela Creaven	Managing Director, Bexley Business Support Unit (Until 31 August 2012)

Dr Ann Marie Connolly	Director of Public Health

[1] *Mr Kenworthy retained Accountable Officer status for the whole of 2012/13*
[2] *Mr Chapman retained Director of Finance Accountable Officer status for the whole of 2012/13*

The declared interests of the Board members are in the following table:

Declaration of Board members personal and financial interests – 2012/2013

<table>
<tr><th>NAME</th><th>Company/ Organisation</th><th>Position/ Shareholding/ remuneration</th><th>Directorships and or other significant interests</th></tr>
<tr><td>Steven Corbishley</td><td>BT</td><td>A small number of shares of insignificant value</td><td>Nil</td></tr>
<tr><td>Paul Cutler</td><td>None</td><td>None</td><td>• Trustee UK Charity Interaction
• Associate for the National Children's Bureau, the Centre for Public Scrutiny and the Health Foundation</td></tr>
<tr><td rowspan="3">Cllr John Davey</td><td>Bexley Council</td><td>Councillor
Remuneration paid</td><td rowspan="3">• Chairman and Trustee of the Arts Council of Bexley
• My wife is head teacher of St Paulinus School, Crayford
• Governor of The New Horizons Federation (a group of three special schools in Bexley)
• Member of Advisory Board of Bedonwell Children's Centre
• Governor at Bedonwell Infant & Nursery School
• Deputy Chairman of Bexleyheath & Crayford Conservative Association</td></tr>
<tr><td>Erith School</td><td>Trustee Governor
No remuneration paid</td></tr>
<tr><td>Orbit South Housing Association</td><td>Service Board Member
No remuneration paid</td></tr>
<tr><td>Susan Free</td><td>Nil</td><td>Nil</td><td>Nil</td></tr>
<tr><td rowspan="2">James Gunner</td><td>London Specialised Commissioning Group</td><td>Non-Executive Director
No remuneration paid</td><td rowspan="2">All of my other business interests have no impact on my NHS responsibilities. They are completely separate and no conflict of interest arises.</td></tr>
<tr><td>Bromley Healthcare</td><td>Governor
No remuneration paid</td></tr>
<tr><td rowspan="2">Harvey Guntrip</td><td>Hadlow College, Kent</td><td>Chairman
No remuneration paid</td><td rowspan="2">Nil</td></tr>
<tr><td>SDM Biomass</td><td>Director</td></tr>
</table>

NAME	Company/ Organisation	Position/ Shareholding/ remuneration	Directorships and or other significant interests
	Limited	50% shareholding No remuneration paid	
	Berties Wood Fuel Ltd	Partner 1/3 shareholder Remuneration paid	
Caroline Hewitt	Withers LLP	Husband is partner in law firm whose clients include some NHS organisations. Remuneration: benefits from profit share	Nil
	VSO UK/VSO International	Member of Audit Committee No remuneration paid	
	Kings College Hospital Charity	Trustee No remuneration paid	
Cllr Eileen Pallen	London Borough of Bexley Council	Councillor, Crayford Ward Remuneration paid	Chairman of Adult Service overview and scrutiny Committee Bexley Council
Keith Wood	(a) Greenwich & Bexley Community Hospice Ltd (b) Different Strokes (Trustees) Ltd	I hold no office in either company nor do I receive any remuneration	Each company is limited by guarantee and I am a member of each company, each member guarantees its liabilities up to a maximum of £1; there are approximately 20 members of (a) & 12 members of (b). (a) has material Service level agreements with Bexley Care Trust & Greenwich TPCT. (b) has no such financial relationships but has a representative on the Bexley stroke round table & is in a position to provide community services in SEL I am a long term user of hospital services in Bromley.

NAME	Company/ Organisation	Position/ Shareholding/ remuneration	Directorships and or other significant interests
Richard Chapman	None	None	Nil
Malcolm Dennett			
Alison Tonge (left)	None	None	Nil
Ann-Marie Connolly (left)	None	None	Nil
Gill Galliano (left)	PCC CIC (Social Enterprise)	Trustee	Nil
Andrew Kenworthy	Diabetes UK Alzheimer's Society British Heart Foundation	Fund-raising for these organisations Wife – Consultancy business, training health professionals on cardio-vascular health and stroke for health communities/organisations across the UK	Nil
Christina Craig	None	None	Nil
Donna Kinnair	Royal College of Nursing Publications	Consultant Editor Expenses paid	Nil
	CWfI (Mouchell)	Board Member No remuneration paid	
	Walworth Academy	School Governor No remuneration paid	
Jane Clegg			

NAME	Company/ Organisation	Position/ Shareholding/ remuneration	Directorships and or other significant interests
Jane Schofield	None	None	Nil
Howard Stoate	The Albion Surgery	Partner Share of Partnership Remuneration paid	Nil
	Bexley Health Limited – clock Tower company	Practice has a share in this company - No remuneration paid	
	Next Step Fostering Agency	Medical Adviser Remuneration paid	
Andrew Bland	None	None	Nil
Angela Bhan	None	None	Nil
Sarah Blow	None	None	Nil
Pamela Creaven (left)	None	None	Nil
Jo Medhurst (left)	GRABADOC (Greenwich and Bexley Association of doctors)	Shareholder – not for profit No shares No remuneration paid	Nil

Board committees:

Bexley Clinical Commissioning Committee

The local clinical commissioning committees (LCCCs) are forerunners to the clinical commissioning groups (CCGs). CCGs will commission some local health services from 1 April 2013. In 2012/13, these clinically led bodies are supported by BSUs to identify local healthcare needs and prioritise commissioning accordingly, providing a local focus to cluster-wide strategies. They also undertake the duties of the professional executive committees (PECs) and provide oversight of local performance.

The Bexley Clinical Commissioning Committee is chaired by Dr Howard Stoate. It meets every other month in public. The full membership as of February 2013 is listed below:

Name	Position
Dr Howard Stoate	Chair
Dr Sid Deshmukh	Locality lead (Frognal)
Dr Varun Bhalla	Locality lead (North Bexley)
Dr Bill Cotter	Locality lead (Clocktower)
Dr Sarah Chase	Locality representative (Frognal)
Dr Sushanta Bhadra	Locality representative (North Bexley),
Dr Gunen Ucyigit	Locality representative (Clocktower),
Keith Wood	Lay member – governance
Sandra Wakeford	Lay member – patient and public involvement
Sarah Blow	Chief officer
Theresa Osborne	Chief financial officer
Yemisi Osho	Nurse
Dr Graham Rehling	Secondary care specialist
Simon Evans-Evans*	Director of governance and quality
Sarah Valentine*	Director of commissioning
Maureen Holkham*	Local authority representative
Ron Brewster*	Bexley patient council representative

** Non-voting members*

There are seven sub groups of the Bexley Clinical Commissioning Committee:

- Executive Management Committee
- Finance Working Group
- Quality and Safety Working Group
- Medicines Management Working Group
- Information Governance Working Group
- Remuneration committee
- Audit and integrated assurance committee

NHS South East London committees and groups

Joint Audit Committee
The Joint Audit Committee fulfils the statutory audit functions required of PCTs and care trusts, ensuring that the governance and machinery of the cluster and the BSUs is functioning as it should. Its work programme includes reviewing governance arrangements (including information governance), assurance mechanisms including the work of internal and external audit, local counter fraud services, debt and waiver management, and reviewing the board assurance framework to make sure that corporate objectives and organisational risks are properly addressed. The Committee meets four times a year and all meetings in 2012/13 were quorate.

Chair: Steven Corbishley
Executive members: Richard Chapman, Acting Director of Finance, Malcolm Dennett, Interim Director of Finance and Jane Schofield, Deputy Chief Executive
Non-executive members: Keith Wood, Harvey Guntrip, Graham Laylee, Rona Nicholson, Robert Park and Jeremy Fraser

Integrated Governance Committee (IGC)
The IGC has the following roles and responsibilities:-

- To oversee the integrated governance of the shadow CCGs and give the Joint Boards assurance that actions and plans put in place by the CCGs are appropriate, adequate and followed through as they work towards Authorisation.
- To give a forum for the shadow CCGs to operate at scale to manage the performance and quality of the major acute, community and mental health providers
- To help enable the Cluster Chief Executive to exercise his role as Accountable Officer through consideration and review of the aggregate Cluster position with respect to performance, finance, quality and emergency planning
- To review and consider the quality and performance of Primary Care, Prison Health and Specialist Services prior to full establishment of the National Commissioning Board
- To oversee the procedures for identifying, investigating and learning for serious incidents and for safeguarding children and vulnerable adults

The Committee meets monthly and all meetings were quorate during 2012/13. Meetings are not held in public but a summary report detailing issues discussed and actions proposed is provided at each Joint Boards meeting. Meetings rotate on a three monthly cycle:

- Lambeth, Southwark and Lewisham (LSL)
- Bexley, Bromley and Greenwich (BBG)
- NHS South East London Cluster (SEL)

Joint Chairs (rotation): Jim Gunner (BBG), Robert Park (LSL), Caroline Hewitt (SEL)
Executive members: Andrew Kenworthy/ Christina Craig, Chief/Interim Chief Executive; Jane Schofield, Deputy Chief Executive; Richard Chapman, Acting Director of Finance; Malcolm Dennett, Interim Director of Finance; Donna Kinnair/ Jane Clegg, Director/ Interim Director of Nursing

Non-executive members: Keith Wood, Susan Free, Rona Nicholson and Sue Gallagher

Handover and Closure Committee
The Handover and Closure Committee oversees all aspects of the Handover and Closure programme in the NHS in South East London leading up to the new NHS commissioning arrangements that come into force on the 1 April 2013. The Committee meets in private but provides its minutes to the Joint Boards. All meetings in 2012/13 were quorate.

Chair: Steven Corbishley
Executive members: Christina Craig, Interim Chief Executive; Jane Schofield, Deputy Chief Executive; Malcolm Dennett, Interim Director of Finance
Non-executive members: All non-executive directors are members of this Committee. At least three must be present (including one from LSL and one from BBG) for the meeting to be quorate.

Capital Strategy Group
The Capital Strategy Group oversees all aspects of Capital Strategy, planning and progress in the NHS in South East London. The Group meets in private but considers issues prior to their decision at public meetings of LCCCs or the Joint Boards. All meetings in 2012/13 were quorate.

Chair: Caroline Hewitt
Executive members: Malcolm Dennett, Interim Director of Finance, Richard Chapman, Director of Finance. All BSU Managing Directors are members of this Committee; at least two must be present for the meeting to be quorate.
Non-executive members: Richard Gibbs, Keith Wood

Employment and Remuneration Committee
The Employment and Remuneration Committee meets to consider the employment packages for those employees of the cluster whose remuneration falls outside the scope of Agenda for Change.

Chair: Caroline Hewitt
Executive members: Una Dalton, Director of Human Resources
Non-executive members: Sue Gallagher, Graham Laylee, Richard Gibbs, Robert Park, Rona Nicholson, David Whiting, Keith Wood, Paul Cutler, Harvey Guntrip, James Gunner, Susan Free and Jeremy Fraser

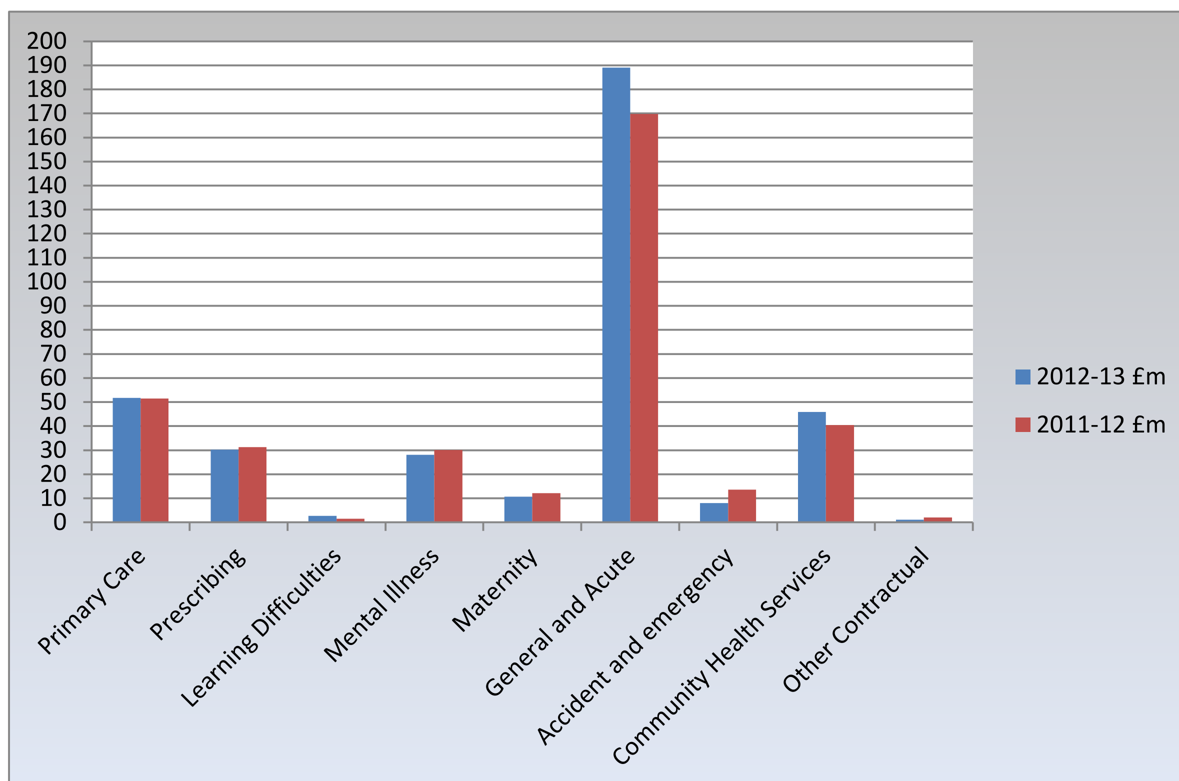
8. How money was spent

8.1 How we spent your money

During 2012/13 we spent:

- **£285.4m on secondary and community healthcare** of which mental health £28m; general & acute £189m, accident & emergency £8m, maternity £10.7m, community £45.9m, learning difficulties £2.7m and other contractual £1.1m.

- **£82m on primary healthcare** of which, primary medical services £29m; prescribing £30m; dental services £11m; non GMS services from GPs £3m; new pharmacy contract £7m and ophthalmic contracts £2m.



9. Remuneration report

9. REMUNERATION REPORT

9.1 Unaudited

The Employment and Remuneration committee of Cluster PCT's meets to consider the employment arrangements for those employees across NHS South East London whose remuneration falls outside the scope of agenda for Change.

The following information relates to the employment of Cluster executive directors and non-executive directors and Chair, Managing Director and Director of Public Health for the PCT.

9.2 Contract details

As a consequence of implementing Health and Social Care Act 2012, all the PCTs and SHAs were abolished on 31st March 2013. Contractual arrangements for officer Board members and Non-executive members, therefore, also terminate on the same date.

Name	Title	Start Date	End Date

Andrew Kenworthy * (to 4/9/2012)	Chief Executive, NHS SEL Cluster	03/10/2011	31/03/2013
Christina Craig *	Interim Chief Executive, NHS SEL Cluster	03/09/2012	31/03/2013
Gill Galliano	Director of Development and Joint Deputy Chief Executive, NHS SEL Cluster	01/04/2011	30/06/2012
Richard Chapman *	Director of Finance, NHS SEL Cluster	01/11/2011	31/03/2013
Alison Tonge *	Interim Director of Finance, NHS SEL Cluster	06/08/2012	15/11/2012
Malcolm Dennett *	Interim Director of Finance, NHS SEL Cluster	14/11/2012	31/03/2013
Jane Schofield	Director of Operations, NHS SEL Cluster	01/04/2011	31/03/2013
Donna Kinnair	Director of Nursing, NHS SEL Cluster	01/04/2011	01/10/2012
Jane Clegg	Director of Nursing, NHS SEL Cluster	09/11/2012	31/03/2013
Caroline Hewitt	Chair, NHS SEL Cluster	01/04/2011	31/03/2013
Steven Corbishley	Non Executive Director, NHS SEL Cluster	01/04/2011	31/03/2013
Cllr John Davey	Non Executive Director, NHS SEL Cluster	25/08/2010	31/03/2013
Cllr Eileen Pallen	Non Executive Director, NHS SEL Cluster	05/08/2010	31/03/2013
Harvey Guntrip	Non Executive Director, NHS SEL Cluster	01/04/2011	31/03/2013
Susan Free	Non Executive Director, NHS SEL Cluster	14/04/2011	31/03/2013
Paul Cutler	Non Executive Director, NHS SEL Cluster	01/04/2007	31/03/2013
Keith Wood	Non Executive Director, NHS SEL Cluster	01/09/2003	31/03/2013

Dr Howard Stoate	Local Clinical Commissioning Committee Chair	01/01/2011	31/03/2013
Pamela Creaven	Director of Public Health and Joint Managing Director	01/04/2007	31/8/2012
Sarah Blow	Joint Managing Director	08/10/2012	31/03/2013
Dr Joanne Medhurst	Joint Managing Director	01/10/2009	31/03/2013

* During 2012-13 both the Accountable Officer and the Statutory Director of Finance moved to new roles within the NHS. However, for the purposes of these statutory roles they continued to assume this accountability through to the 31 March 2013 and they attended both Joint Boards and Audit Committees. To recognise the requirement for leadership, as a result of these moves, an interim Chief Executive was appointed through to the 31 March and an Interim Finance Director. The Interim Finance Director appointment changed during the course of the year.

9.3 Senior Management cost sharing arrangements

The PCT senior management comprises cluster posts of Chair, Chief Executive and Directors of Finance, Corporate Development, Operations and Nursing shared equally across the five PCTs and the Care Trust in the Cluster. The Non-Executive directors appointed to the Cluster Board are shared equally across their representation of separate health economies of LSL (Lambeth, Southwark and Lewisham PCTs) and BBG (Bexley Care Trust, Bromley and Greenwich PCTs). The rest of the PCT Board consists of local Managing Director, Director of Public Health and GP lead Chair of the PCT's Clinical Commissioning Committee.

9.4 The costs of the Executive and Non-Executive members reported below are the PCT's share of costs, where relevant, in the line with the arrangements described above.

Audited

Cluster Board Executive and Non-Executive members (*PCT's share of costs*)

Salaries and allowances

Name	Title	2012/13				2011/12			
		Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (rounded to the nearest £00)
Andrew Kenworthy (to 4/9/2012)	Chief Executive, NHS SEL Cluster	5-10				10-15			
Simon Robbins (to 31/08/2011)	Chief Executive, NHS SSEL Cluster					10-15			
Christina Craig (from 3/9/2012)	Interim Chief Executive, NHS SEL Cluster	25-30							
Gill Galliano (to 30/6/2012)	Director of Development and Joint Deputy Chief Executive, NHS SEL Cluster	5-10				20-25			
Richard Chapman	Director of Finance, NHS SEL Cluster	15-20				10-15			
Alison Tonge (from 6/8/2012 to 15/11/2012)	Interim Director of Finance, NHS SEL Cluster	10-15							
Malcolm Dennett (from 14/11/2012)	Interim Director of Finance, NHS SEL Cluster	10-15							
Jane Schofield	Director of Operations, NHS SEL Cluster	20-25	40-45			20-25			
Donna Kinnair (to 1/10/2012)	Director of Nursing, NHS SEL Cluster	15-20	15-20			15-20			
Jane Clegg (from 1/10/2012)	Director of Nursing, NHS SEL Cluster	5-10							
Caroline Hewitt	Chair, NHS SEL Cluster	5-10				5-10			
Steven Corbishley (No remuneration paid)	Non Executive Director, NHS SEL Cluster	0				0			
Paul Cutler	Non Executive Director, NHS SEL Cluster	1-5				1-5			
Susan Free	Non Executive Director, NHS SEL Cluster	1-5				1-5			
Cllr Eileen Pallen	Non Executive Director, NHS SEL Cluster	1-5				1-5			
Cllr John Davey	Non Executive Director, NHS SEL Cluster	1-5				5-10			
Harvey Guntrip	Non Executive Director, NHS SEL Cluster	1-5				1-5			
Keith Wood	Non Executive Director, NHS SEL Cluster	1-5				1-5			

Bexley PCT senior staff – these staff represent Bexley Care Trust on Cluster Board.
Salaries and allowances

		2012/13				2011/12			
		Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (rounded to the nearest £00)
Dr Howard Stoate	Local Clinical Commissioning Committee Chair	75-80				60-65			
Pamela Creaven	Director of Public Health and Joint Managing Director	15-20				85-90			
Sarah Blow	Joint Managing Director	50-55							
Dr Joanne Medhurst	Joint Managing Director	60-65				110-115			

Pension Benefits (*PCT's share of Pension entitlement costs*)

Non-Executive directors on the Board and General Practitioners on Clinical Commissioning Collaborative Committee are not employed by the PCT and are not members of the NHS pension scheme. Their pension benefits are, therefore, not required to be reported in the remuneration report.

In line with the guidance in the Manual of Accounts, it is not possible to apportion the cash equivalent transfer value (CETV) across the PCTs and Care Trust in the Cluster on any systematic basis. This has been, therefore, reported below in full.

Name	Title	Real increase in pension at age 60	Real increase in pension lump sum at aged 60	Total accrued pension at age 60 at 31 March 2013	Lump Sum at age 60 related to accrued pension at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real increase in Cash Equivalent Transfer Value	Employer contribution to stakeholder pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£'000	£'000	£'000	£'000
Andrew Kenworthy	Chief Executive, NHS SEL Cluster	0-2.5	0-2.5	5-10	25-30	896	872	24	
Gill Galliano (to 30/6/2012)	Director of Development and Joint Deputy Chief Executive, NHS SEL Cluster	0-2.5	0-2.5	5-10	20-25	0	912	-912	
Richard Chapman	Director of Finance, NHS SEL Cluster	0-2.5	2.5-5	2.5-5	10-15	287	202	84	
Jane Schofield (Left Pension scheme 2011-12 restated)	Director of Operations, NHS SEL Cluster	0-2.5	0-2.5	5-10	25-30	1157	1217	-60	
Donna Kinnair (to 1/10/2012)	Director of Nursing, NHS SEL Cluster	0-2.5	2.5-5	5-10	10-15	565	500	65	
Dr Joanne Medhurst	Joint Managing Director	0-2.5	5-7.5	35-40	95-100	538	490	48	
Sarah Blow	Joint Managing Director	0-2.5	5-7.5	15-20	45-50	251	210	41	
Pamela Creaven	Director of Public Health and Joint Managing Director	0-2.5	0-2.5	5-10	0	75	58	17	

9.5 The costs of Cluster Board executive and Non-Executive members, reported below are the total remuneration and pension entitlement of the individual. These costs are shared across the six PCTs and Care Trust in South East London.

Cluster Board Executive and Non-Executive members *(Total remuneration)*

Salaries and allowances

Name	Title	2012/13				2011/12			
		Salary (bands of £5,000	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (rounded to the nearest £00)
		£000	£000	£000	£00	£000	£000	£000	£00
Andrew Kenworthy (to 4.9.2012)	Chief Executive, NHS SEL Cluster	45-50				85-90			
Simon Robbins (to 31/08/2011)	Chief Executive, NHS SSEL Cluster					60-65			
Christina Craig (from 3.9.2012)	Interim Chief Executive, NHS SEL Cluster	155-160							
Gill Galliano (to 30.6.2012)	Director of Development, NHS SEL Cluster	30-35				125-130			
Jane Schofield	Director of Operations, NHS SEL Cluster	130-135	260-265			130-135			
Richard Chapman	Director of Finance, NHS SEL Cluster	110-115				65-70			
Alison Tonge (from 6.8.12 to 15.11.2012)	Interim Director of Finance, NHS SEL Cluster	80-85							
Malcolm Dennett (from 14.11.2012)	Interim Director of Finance, NHS SEL Cluster	70-75							
Donna Kinnair (to 1.10.2012)	Director of Nursing, NHS SEL Cluster	95-100	105-110			95-100			
Jane Clegg (from 1.10.2012)	Director of Nursing, NHS SEL Cluster	50-55							
Caroline Hewitt	Chair, NHS SEL Cluster	40-45				40-45			
Steven Corbishley	Non Executive Director, NHS SEL Cluster	Nil Remuneration				Nil Remuneration			
Paul Cutler	Non Executive Director, NHS SEL Cluster	5-10				5-10			
Susan Free	Non Executive Director, NHS SEL Cluster	5-10				5-10			
Cllr Eileen Pallen	Non Executive Director, NHS SEL Cluster	5-10				5-10			
Cllr John Davey	Non Executive Director, NHS SEL Cluster	10-15				5-10			
Harvey Guntrip	Non Executive Director, NHS SEL Cluster	10-15				5-10			
Keith Wood	Non Executive Director, NHS SEL Cluster	10-15				10-15			

Bexley PCT senior staff – these staff represent Bexley Care Trust on Cluster Board.
Salaries and allowances

		2012/13				2011/12			
		Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (rounded to the nearest £00)
Dr Howard Stoate	Local Clinical Commissioning Committee Chair	75-80				60-65			
Pamela Creaven	Director of Public Health and Joint Managing Director	15-20				85-90			
Sarah Blow	Joint Managing Director	50-55							
Dr Joanne Medhurst	Joint Managing Director	60-65				110-115			

Pension Benefits *(Total Pension entitlement)*

Name	Title	Real increase in pension at age 60	Real increase in pension lump sum at aged 60	Total accrued pension at age 60 at 31 March 2013	Lump Sum at age 60 related to accrued pension at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real increase in Cash Equivalent Transfer Value	Employer contribution to stakeholder pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£'000	£'000	£'000	£'000
Andrew Kenworthy	Chief Executive, NHS SEL Cluster	0-2.5	0-2.5	50-55	155-160	896	872	24	
Gill Galliano (to 30/6/2012)	Director of Development and Joint Deputy Chief Executive, NHS SEL Cluster	0-2.5	0-2.5	45-50	145-150	0	912	-912	
Richard Chapman	Director of Finance, NHS SEL Cluster	5-7.5	17.5-20	20-25	60-65	287	202	84	
Jane Schofield (Left Pension scheme 2011-12 restated)	Director of Operations, NHS SEL Cluster	0-2.5	0-2.5	55-60	165-170	1157	1217	-60	
Donna Kinnair (to 1/10/2012)	Director of Nursing, NHS SEL Cluster	0-2.5	2.5-5	25-30	85-90	565	500	65	
Dr Joanne Medhurst	Joint Managing Director	0-2.5	5-7.5	35-40	95-100	538	490	48	
Sarah Blow	Joint Managing Director	0-2.5	5-7.5	15-20	45-50	251	210	41	
Pamela Creaven	Director of Public Health and Joint Managing Director	0-2.5	0-2.5	5-10	0	75	58	17	

* The information for the increase in real pension and lump sum cannot be calculated for new members of staff as the information reported in the previous year is not available.

9.6 Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, ***contributions paid by the employee*** (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

9.7 Pay Multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in Bexley PCT in the financial year 2012-13 was £102,500 (2011-12, £112,162). This was 2.66 times (2011-12 2.95 times) the median remuneration of the workforce, which was £38,540 (2011-12 £38,000).

In 2012-13, 0 (2011-12, one) employee received remuneration in excess of the highest paid director. Remuneration ranged from £7,881 to £101,829 (2011-12 £19,809 to £112,162). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind excluding severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The reduction in the multiple between 2011-12 and 2012-13 is due to the changes in the salary of the highest paid director from £112,162 to £101,829 as well as the small increase in the median salary from £38,000 to £38,540.

9.8 Exit Packages

	2012-13			2011-12		
Exit package cost band (including any special payment element)	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
Lees than £10,000	2	0	2	0	0	0
£10,001-£25,000	3	0	3	0	0	0
£25,001-£50,000	4	0	4	0	0	0
Total number of exit packages by type (total cost	9	0	9	0	0	0
	£	£	£	£	£	£
Total resource cost	225,730	0	225,730	0	0	0

9.9 Off Payroll Engagements – *(unaudited)*

Table 1: For off-payroll engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012	Bexley Care Trust
	No.
No. in place on 31 January 2012	6
of which	
No that have since come onto the organisation's payroll	0
of which	
No. that have since been re-negotiated/re-engaged, to include contractual clauses allowing the department to seek assurance as to their tax obligations	0
No. that have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the department to seek assurance as to their tax obligations	1
No. that have come to an end (**31st March 2013**)	5
Total	6

Table 2: For all off-payroll engagements between 23 August 2012 and 31 March 2013, for more than £220 per day and more than 6 months.	
	Bexley CT
No. of new engagements	1
of which	
No of new engagements which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance Obligations	1
of which	
No. for whom assurance has been requested and received	0
No. for whom assurance has been requested but not received (See Below)	0
No. that have been terminated as a result of assurance not being received	
No. for whom assurance was not required due to	
Left the organisation	1
Joined an agency	0
Enetered substantive employment	0
Request not made	0

9.10 Related Party Transactions

Bexley Primary Care Trust is a body corporate established by order of the Secretary of State for Health.

Based upon declarations of interest made by Executive, Non Executive and Borough Clinical Commissioning Collaborative Committee members, related parties were identified and the value of transactions are included below.

Details of related party transactions with individuals during 2012/13 are as follows:

	Services Received from Organisation	Payments to Related Party
		£'s
Dr V Bhalla - Belvedere Medical Practice	Primary Care	815,940
Dr W Cotter - Bellegrove Surgery	Primary Care	1,584,716
Dr W Cotter - Clocktower Healthcare Ltd	Primary Care	559,462
Dr W Cotter - Bellegrove Medical Services Ltd	Primary Care	16,215
Dr S Deshmukh - Sidcup Medical Centre	Primary Care	853,115
Dr S Chase - Woodlands Primary Care	Primary Care	1,291,542
Dr S Bhadra - Goodhealth PMS	Primary Care	758,514

The Department of Health is regarded as a related party. During the year Bexley Care Trust had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent Department.

		£000's
Dartford and Gravesham NHS Trust	Provision of Healthcare	26,225
South London Healthcare Trust	Provision of Healthcare	95,506
Guys And St Thomas NHS Foundation Trust	Provision of Healthcare	29,817
Oxleas NHS Foundation Trust	Provision of Healthcare	43,609
London Borough of Bexley	Healthcare from non-NHS Bodies	7,846

10. HOW WE SPENT YOUR MONEY

BEXLEY CARE TRUST SUMMARY FINANCIAL STATEMENTS 2012/13

These summary financial statements are a summary of the information in the Care Trust's full annual accounts for 2012/13. The summary financial statements might not contain

sufficient information for a full understanding of the Care Trust's financial position and performance.

IFRSs are accounting standards issued by the International Accounting Standards Board (IASB). The term IFRS refers to the international equivalent to UK GAAP, the set of Generally Accepted Accounting Principles that includes accounting standards, interpretations, the IASB's framework and established accounting practice. The Chancellor's 2007 Budget announced that the accounts of central government departments and entities in the wider public sector will be produced using IFRS, as interpreted for the public sector in the IFRS-based Financial Reporting Manual (FReM). Central government, NHS Trusts, Primary Care Trusts and NHS Foundation Trusts all need to adopt IFRS and the annual accounts for government organisations and the NHS are to be prepared using IFRS standards.

10.1 PCT FINANCIAL PERFORMANCE 2012/2013

Statutory and other financial duties

The Care Trust is required by statute to meet certain financial duties in order to ensure that public funds are used appropriately. These duties are:

- not to exceed the PCT's revenue resource limit;
- not to exceed the PCT's capital resource limit;
- not to exceed the (combined) revenue and capital cash limits

Bexley Care Trust met all of its statutory duties in full in 2012/13.

Financial balance

PCTs and Care Trust have a statutory duty to keep expenditure within the resource limits set by the Department of Health for revenue and capital separately. The PCT's audited annual accounts show a surplus of £3.518m on revenue and £0.009m on capital.

	2012/13 Revenue £000	**2012/13 Capital £000**	**2012/13 Total £000**
Resource Limit	378,784	1,185	379,969
Net Operating Costs	375,267	1,176	376,443
Surplus / (Deficit)	**3,517**	**9**	**3,526**

All the Primary Care Trusts and Strategic Health Authorities were abolished from 1 April 2013. Under Department of Health year-end carry forward arrangements and guidance around financial planning for 2013/14, Bexley Care Trust has been advised by DH to assume 71.86% as a carry forward resource in 2013/14 plans. Underspends against Capital Resource Limits are not carried forward. PCTs bid for capital resources on an annual basis.

Cash performance

The PCT has a statutory duty to remain within its set cash limit. There is a single cash limit covering both revenue and capital. The PCT under drew its 2012/13 cash limit of £375.121m by £10.5m. The Department of Health also sets a maximum year-end cash balance for PCTs of £50k. The PCT's cash balance as at 31st March 2013 was £302k.

	£000
Opening Cash balance 1 April 2012	1
Cash drawings including cash top sliced by DH	375,121
Cash Outgoings	364,320
Cash returned to DH	10,500
Closing cash balance 31 March 2013	**302**

Capital charges

Capital charges were introduced in the NHS in 1991 to increase awareness of the cost of owning assets. The amount payable is based on the actual opening and closing Balance Sheets for the year. There are two elements to this: depreciation of fixed assets and a charge of 3.5 per cent on net relevant assets. The Department of Health has revised the mechanism for charging capital charges interest since 2011/12. The Care Trust revenue resources for 2012/13 were increased by £385k for capital charges interest. Capital charges for Bexley Care Trust for 2012/13 were as follows:

	£000
Depreciation	778
3.5% cost of capital charge on net relevant assets	(322)
Total	**456**

Public sector payment targets

In addition to the PCT's statutory targets, the Department of Health requires that NHS bodies pay their creditors in accordance with the Prompt Payment Code (PPC) and government accounting rules. The target is to pay 95 per cent of all creditors within 30 days of receipt of the goods or a valid invoice (whichever is later) unless other payment terms have been agreed with the supplier. Bexley Care Trust is an approved signatory to the Prompt Payment Code. The PCT's performance against this target is reported below:

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**7,509**	**37,927**	13,452	34,699
Total Non-NHS Trade Invoices Paid Within Target	**6,385**	**34,215**	12,065	29,809
Percentage of NHS Trade Invoices Paid Within Target	85.03%	90.21%	89.69%	85.91%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,663**	**294,266**	3,132	259,217
Total NHS Trade Invoices Paid Within Target	**3,147**	**290,788**	2,736	249,070
Percentage of NHS Trade Invoices Paid Within Target	85.91%	98.82%	87.36%	96.09%

The Better Payment Practice Code requires the Care Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

Comparisons of 2012/13 annual accounts with previous years

1 Net operating costs

The overall growth in net operating costs of £21m (5.9%) since 2011/12 reflects the funding growth received by the PCT during 2012/13.

	2009/10	2010/11	2011/12	2012/13	Change from 2011/12	
	£m	£m	£m	£m	£m	%
Gross Operating Costs	329	353	360	382	22	6.1%
Including income of	3	7	6	7	1	16.7%
Net Operating Costs	**326**	**346**	**354**	375	21	**5.9%**

2 Non-Current Assets

Bexley Care Trust's fixed assets have been reviewed by the District Valuer as at 31 March 2013 by carrying out a valuation exercise. This resulted in a net decrease in asset values of £0.970m. During the year the Trust incurred capital spend of £1.176m.

3 Net Current Liabilities

	2009/10 £m	2010/11 £m	2011/12 £m	2012/13 £m	Change £m
Current Assets	7	2	6	3	(3)
Current Liabilities	(27)	(20)	(22)	(29)	(7)
Net Current Liabilities	**(20)**	**(18)**	**(16)**	**(26)**	**(10)**

4 Taxpayers' equity

	2009/10 £m	2010/11 £m	2011/12 £m	2012/13 £m	Change £m
General Fund	(10)	(10)	(8)	(19)	(11)
Revaluation Reserve	5	4	5	4	(1)
Total	(5)	(6)	(3)	(15)	(12)

5 Pensions

Past and present employees are covered by the provisions of the NHS Pensions Scheme. For full details of how pension liabilities are treated please see Note 1.24 Accounting Policies in the Annual Accounts. For details of senior manager's pension entitlements please see the PCT's remuneration report.

Statement of cash flows for the year ended 31 March 2013

	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities		
Net Operating Cost Before Interest	**(375,184)**	(354,097)
Depreciation and Amortisation	**778**	1,018
Impairments and Reversals	**0**	94
Interest Paid	**(260)**	(402)
(Increase)/Decrease in Trade and Other Receivables	**3,089**	(4,012)
Increase/(Decrease) in Trade and Other Payables	**1,731**	1,642
Provisions Utilised	**(350)**	(148)
Increase/(Decrease) in Provisions	**7,183**	124
Net Cash Inflow/(Outflow) from Operating Activities	**(363,012)**	**(355,781)**
Cash flows from investing activities		
Interest Received	**178**	59
(Payments) for Property, Plant and Equipment	**(1,220)**	(133)
(Payments) for Other Financial Assets	**(131)**	0
(Payments) for Financial Assets (LIFT)	**0**	(7)
Net Cash Inflow/(Outflow) from Investing Activities	**(1,173)**	**(81)**
Net cash inflow/(outflow) before financing	**(364,185)**	**(355,862)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP LIFT	**(135)**	(134)
Net Parliamentary Funding	**364,621**	355,963
Net Cash Inflow/(Outflow) from Financing Activities	**364,486**	**355,829**
Net increase/(decrease) in cash and cash equivalents	**301**	**(33)**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**1**	**34**
Cash and Cash Equivalents (and Bank Overdraft) at year end	**302**	**1**

Statement of Financial Position at 31 March 2013

	31 March 2013	31 March 2012
	£000	£000
Non-current assets:		
Property, plant and equipment	**17,145**	17,717
Other financial assets	**289**	158
Trade and other receivables	**152**	151
Total non-current assets	**17,586**	18,026
Current assets:		
Trade and other receivables	**2,972**	6,018
Cash and cash equivalents	**302**	1
Total current assets	**3,274**	6,019
Total current assets	**3,274**	6,019
Total assets	**20,860**	24,045
Current liabilities		
Trade and other payables	**(23,913)**	(22,182)
Provisions	**(4,685)**	(145)
Borrowings	**(163)**	(134)
Total current liabilities	**(28,761)**	(22,461)
Non-current assets plus/less net current assets/liabilities	**(7,901)**	1,585
Non-current liabilities		
Provisions	(2,632)	(338)
Borrowings	(4,309)	(4,473)
Total non-current liabilities	**(6,941)**	(4,811)
Total Assets Employed:	**(14,842)**	(3,227)
Financed by taxpayers' equity:		
General fund	(19,181)	(8,535)
Revaluation reserve	4,338	5,308
Total taxpayers' equity:	**(14,842)**	(3,227)

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure		
Gross employee benefits	**5,813**	4,388
Other costs	**376,213**	355,332
Income	**(6,842)**	(5,623)
Net operating costs before interest	**375,184**	354,097
Investment income	**(177)**	(59)
Finance costs	**260**	411
Net operating costs for the financial year	**375,267**	354,449
Transfers by absorption -(gains)	**0**	0
Transfers by absorption - losses	**0**	0
Net (gain)/loss on transfers by absorption	**0**	0
Net Operating Costs for the Financial Year including absorption transfers	**375,267**	**354,449**
Of which:		
Administration Costs		
Gross employee benefits	**2,969**	2,757
Other costs	**3,685**	4,232
Income	**(341)**	(359)
Net administration costs before interest	**6,313**	**6,630**
Investment income	**(177)**	0
Finance costs	**0**	0
Net administration costs for the financial year	**6,136**	**6,630**
Programme Expenditure		
Gross employee benefits	**2,844**	1,631
Other costs	**372,528**	351,100
Income	**(6,501)**	(5,264)
Net programme expenditure before interest	**368,871**	**347,467**
Investment income	**0**	(59)
Finance costs	**260**	411
Net programme expenditure for the financial year	**369,131**	**347,819**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**1,402**	787
Net (gain) on revaluation of property, plant & equipment	**(432)**	(858)
Total comprehensive net expenditure for the year*	**376,237**	**354,378**

10 POST BALANCE SHEET EVENTS

As disclosed within note 1.1 due to the Health and Social Care Bill as of 1st April 2013 the PCT in its current legal form will be abolished. As a result the PCT's functions will continue with either a Commissioning Support Unit (CSU), Clinical Commissioning Group (CCG), NHS England, NHS Foundation Trusts (FT) or Local Authorities (LA). Estates functions will be transferred to NHS Property Services Limited (NHS PS). Ultimate control will still reside with the Department of Health.

All assets and liabilites contained within the statement of financial position as at 31st March 2013 must be identified and agreed for transfer.

Under this NHS Transition, the PCT's assets and liabilities will be split between different 'Receivers' and, in some cases, multiple 'Receivers' will require access to an asset or be assigned a liability. The principles for the split of residual balances is still subject to Department of Health guidance.

The majority of assets and liabilities (including all land and buildings) will transfer by way of a 'Sender' organisation's Transfer Schemes. A Transfer Scheme is an instrument in writing made by the Secretary of State under sections 300 to 302 of the Act. It can deal with the transfers of staff, property and liabilities between those entities as specified in Schedules 22 and 23 to the Act but unlike Transfer Orders does not need to be laid before Parliament.

Where functions transfer, any claim, liability and financial asset, which relate to that will follow. However NHS England will take historical NHS Litigation Authority (NHSLA) indemnified clinical negligence claims, including those incurred but not reported relating to new functions of CCG's or Local Authorities.

The final year-end aggregate surplus generated by the PCTs in 2012/13 will be carried forward to NHS England in 2013/14. CCGs will not inherit legacy debt, but balances will transfer from PCTs, in line with provisions of the Act, based on the principles set out below, subject to further guidance from the Department of health on the split of financial balances and related financial transactions.

- Liabilities that correspond to an asset which relate to a particular function should transfer with that asset from a sender to a receiver by reference to the destination of the function.

- Liabilities that correspond to a function or policy that is being moved from a sender should transfer to the nominated receiver for that function.

- Discrete, and current assets and liabilities, even if associated with a function continuing in 2013/14 will transfer to the Department of Health.

- Liabilities relating to the PCT as a statutory body in its own right that do not relate to an ongoing function such as VAT or tax liabilities, will transfer to the Department of Health.

- Employer liabilities will transfer to the new employer, where an individual's employment is transferred to a receiver organisation.

- Where employment of staff ceases prior to 1st April 2013, the employer liabilities related to those staff members will transfer to Department of Health.

11 Running costs

PCTs are required to report the proportion of their costs per head of local weighted population that is spent on management. The Department of Health (DH) has issued guidance on the definition of running costs.

	2012/13	2011/12	Change
Running costs (£000s)	6,403	6,630	(227)
Weighted population (number)	212,833	212,833	-
Management cost per head of weighted population (£)	**30**	**31**	**(3.42%)**

The PCT measures its running costs according to the definitions provided by the Department of Health.

The PCT running costs for 2012/13 have been increased by £0.125m (1.88%) in the year.

Audit

The PCT's external auditor is Grant Thornton. During the financial year 2012/13 £97k (including VAT) was paid in respect of carrying out the external audit of the PCT in accordance with the Code of Audit Practice.

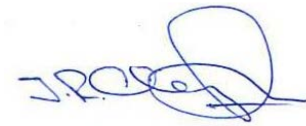
2012/13 Accounts Certificate of Financial Assurance to the Department of Health Director General, Strategy Finance and NHS

I am aware that as signing officer designated by the Department of Health Accounting Officer, you are required to sign the accounts and supporting certificates of Bexley Care Trust (CT) in order to comply with the Department's 2012/13 accounts finalisation process.

To assist you in that process, I can confirm that in my role managing the preparation of the annual statutory accounts, the accounts were prepared in the format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the net operating cost, recognised gains and losses and cash flows for the year. As required the accounts:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

Richard Chapman
Director of Finance SEL Cluster 2012/13



Signature:

Date: 24 April 2013

2012/13 Accounts Certificate of Assurance to the Department of Health Director General, Strategy Finance and NHS

I am aware that as signing officer designated by the Department of Health Accounting Officer, you are required to sign the accounts and supporting certificates of Bexley Care Trust (CT) in order to comply with the Department's 2012/13 accounts finalisation process.

To assist you in that process, I can confirm that for the year ended 31 March 2013 based on my own knowledge of internal control matters and through experience in my role as Accountable Officer until 31 March 2013, the CT:

- had in place effective management systems to safeguard public funds and assets and assist in the implementation of corporate governance;
- kept proper accounting records which disclosed with reasonable accuracy at any time the financial position of the CT;
- took reasonable steps for the prevention and detection of fraud and other irregularities;
- achieved value for money from the resources available to the CT;
- applied income and expenditure to the purposes intended by Parliament and conformed to the authorities which governed them; and
- had effective and sound financial management systems in place.

I also confirm that in my role overseeing the preparation of the annual statutory accounts, the accounts were prepared in the format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the net operating cost, recognised gains and losses and cash flows for the year. As required the accounts;

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

Name: Andrew Kenworthy

Signature:

Date: 24 April 2013

STATEMENT OF THE RESPONSIBILITIES OF THE SIGNING OFFICER OF THE PRIMARY CARE TRUST 2012-13 ACCOUNTS

The Department of Health's Accounting Officer has designated the role of signing officer for the final accounts of Bexley Care Trust to discharge the following responsibilities for the Department of Health:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to the primary care trust;

- the expenditure and income of the primary care trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are in place; and

- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the net operating cost, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, and from the assurances provided by the Care Trust Accountable Officer until 31 March 2013, I am assured that the responsibilities have been properly discharged.

Signed..

Date 31 May 2013

Carl Vincent
Director of Provider Finance and Finance Transition

INDEPENDENT AUDITOR'S REPORT TO THE DEPARTMENT OF HEALTH'S ACCOUNTING OFFICER IN RESPECT OF BEXLEY CARE TRUST

We have examined the summary financial statements for the year ended 31 March 2013 which comprises the Statement of Cashflows, the Statement of Financial Position and the Statement of Comprehensive Net Expenditure and the related notes.

This report is made solely to the Department of Health's Accounting Officer in respect of Bexley Care Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Department of Health's accounting officer and the Trust as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of directors and auditor

The Signing Officer is responsible for preparing the Annual Report.

Our responsibility is to report to you our opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements.

We also read the other information contained in the Annual Report and consider the implications for our report if we become aware of any misstatements or material inconsistencies with the summary financial statement.

We conducted our work in accordance with Bulletin 2008/03 "The auditor's statement on the summary financial statement in the United Kingdom" issued by the Auditing Practices Board. Our report on the statutory financial statements describes the basis of our opinion on those financial statements.

Opinion

In our opinion the summary financial statement is consistent with the statutory financial statements of the Bexley Care Trust for the year ended 31 March 2013.

Grant Thornton UK LLP
Grant Thornton House
Melton Street, Euston Square
London
NW1 2EP

The Annual Report including the remuneration report was approved by the DH authorised signatory at the DH sub Audit Committee for South East London on 31 May 2013.

Carl Vincent
Director of Provider Finance and Finance Transition

10. Further information

A copy of the 2012/13 audited annual accounts as well as the Care Trust Annual Governance Statement is available from:

Theresa Osborne
Chief Financial Officer
Bexley CCG
221 Erith Road, Bexleyheath, Kent DA7 6HZ
Tel 020 8298 6238
Theresa.osborne@bexley.nhs.uk

Bexley Care Trust

2012-13 Accounts

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Bexley Care Trust

2012-13 Accounts

Bexley NHS Care Trust

Annual Accounts

Year Ended 31st March 2013

FOREWORD TO THE ACCOUNTS

BEXLEY NHS CARE TRUST

These accounts for the year ended 31st March 2013 have been prepared by the Bexley NHS Care Trust under section 98(2) of the National Health Service Act 1977 in the form which the Secretary of State has, with the approval of the Treasury, directed.

BEXLEY CARE TRUST

NATIONAL HEALTH SERVICE

ANNUAL ACCOUNTS 2012/13

The Accounts of Bexley Care Trust

1) Introduction

Bexley Care Trust (BCT) was a public body and part of the National Health Service. It was a statutory body governed by Acts of Parliament and came into existence on the 1st October 2003.

BCT brought together some of the staff and services previously provided by London Borough of Bexley Social Services and all the staff, services and functions previously provided by Bexley Primary Care Trust. However, with effect from 01/04/2009, these Social Services staff, services and functions transferred back to the Local Authority. BCT retains its status as a Care Trust as there are other Section 75 agreements in place. BCT is responsible for improving the health of local people and for commissioning primary, community, hospital and other health services for people registered with GP practices in the London Borough of Bexley. 2012/13 is BCT's eighth and last full financial year.

Our Mission and Vision

Our Mission is: **Driving change in the way we deliver care in Bexley**.

Our vision is: **Excellent Healthcare, Locally delivered** and concentrates on five goals:

Improving Health: Improving the health and wellbeing of the local population;

Long-term conditions: Improve care for patients with long-term conditions;

Sexual Health: Empower the population of Bexley to make informed choices about their sexual health;

Mental Health: Greater focus on mental health and wellbeing;

Child Health: Improve the life chances of local children.

These are underpinned by Bexley Care Trust's Organisation Values:

1. Patient first and always: we will ensure all people receive a high quality and appropriate service in line with our strategic objectives.

2. Responsibility: we will be an open, accountable organisation, delivering quality, affordable outcomes.

3. Quality outcomes: we will deliver the highest standards of service to all, in a timely, cost effective and appropriate manner.

In 2012/13, the Care Trust employed 94 staff, of which 75 are permanently employed (average staff numbers).

Within Bexley there are 28 GP Practices, with over 114 GPs, 46 pharmacies, 30 NHS dental practices and 19 ophthalmic practices.

Acute hospital services are commissioned mainly from South London Healthcare NHS Trust, Guy's & St Thomas' NHS Foundation Trust and Dartford and Gravesham NHS Trust. Mental health services are commissioned mainly from Oxleas NHS Foundation Trust in conjunction with the London Borough of Bexley.

Since transfer of Community Provider Services to Oxleas on 1st July 2010, estates and facilities support have been provided by Oxleas NHS Foundation Trust. Until 1st October 2011, Oxleas also provided the Care Trust's General Ledger and Creditor payments functions. In line with the other five South East London Primary Care Trusts (CTs), this support is now provided by Shared Business Services (SBS), the nationally preferred system. SBS is a 50:50 owned joint venture between the NHS and a private sector organisation (Xansa) providing financial and accounting services to the NHS since 2005. Oxleas continue to provide BCT's payroll and pension services.

During 2012/13 BCT worked with the other five PCTs across South East London (Lambeth, Southwark, Lewisham, Bromley and Greenwich) to further develop collective PCT arrangements to achieve improved value for money and to ensure ongoing delivery, to deliver operating cost reductions. On 1st April 2011, the Boards of the six South East London PCTs were merged in a joint board held by NHS South East London (NHSSEL). A range of roles and functions, including Financial Accounts, Primary Care contracting, Human Resources and Acute services contracting were also transferred, and delivered across the six South East London PCTs, for 2011/12 by NHSSEL. This was in line with national transition guidance following the publication of the Government's proposals for the NHS as set out in Equity and Excellence: Liberating the NHS.

The following pages set out the Care Trust's audited Annual Accounts for 2012/13.

Further information about the Care Trust can be obtained from the BCTs website at - **www.bexley.nhs.uk**

Further copies of the Care Trust's 2012/13 Final Accounts and Annual Report can be
Theresa Osborne
NHS Bexley CCG
221 Erith Road, Bexleyheath
Kent, DA7 5SA
Telephone 0208 298 6238
E-mail: theresa.osborne@bexley.nhs.uk

2) Bexley's Population and Local Health

Overview:
Bexley is an outer London Borough with a northern boundary on the river Thames and is situated between Bromley, Greenwich and Dartford. It is generally considered an affluent suburban borough. Bexley has 21 electoral wards.

The Greater London Authority (GLA) 2011 population estimates for 2011 show the Bexley resident population as 220,223. This population is predicted to increase to 224,038 by 2020. The current largest ward populations are Thamesmead East, Erith and Christchurch. The greatest population increases between 2010 and 2016 are expected in the Christchurch, Erith and Barnehurst wards. The current population registered with general practices in Bexley is 229,366.

Bexley has an ageing population compared to London. The largest proportion of females is in the 45-49 age band and in men it is the 30-34 age band. The proportion of residents over 65 has been projected to increase from 2006 to 2016, whereas a decrease has been projected for residents between ages 15-64. There will therefore be a higher need for services associated with older age. Population projections published by the GLA in 2011 illustrate a projected decrease in all White ethnic groups and an increase in all Black and Asian Minority Ethnic (BAME) groups in Bexley. This projection is highest in Black African groups.

Live birth counts between 1990-2007 illustrate an overall decrease in births in Bexley since 1990, lower than neighbouring boroughs in South East London.

Bexley Care Trust sits in the 111th position of Primary Care Trust (CT) deprivation out of the 152 Primary Care Trusts in England (where 1 is the most and 152 the least deprived). The Thames corridor between the wards of Thamesmead East and North End are the most deprived areas.

There is a well-established link between social factors including unemployment, education, deprivation, ethnicity and poor housing with ill health and health inequalities in the community.

Office for National Statistics figures for financial year end (FYE) March 2010 indicate that 76.6% of Bexley's economically active residents are in employment. However, between 2009 and 2010, the number of economically inactive residents increased by 17% to 34,300. Over the same period the number of people claiming out of work benefits has risen by 2%. The economic downturn has had a significant impact in Bexley with unemployment rising from a fairly steady 2,300 in 2006 to more than 5,000 in February 2010 – recent research commissioned by the London Borough of Bexley indicated that Slade Green was one of the wards most affected by increased claimant counts during the recession.

Local intelligence shows that the majority of households in Bexley (40%) are comprised of older families, of which over half are middle aged, middle income owner occupiers living on very large developments of 1930s suburban semi-detached housing.

National Online Manpower Information System (NOMIS) official labour market statistics show that nearly 36% of jobs in Bexley are part-time which should be considered alongside apparent high levels of employment. Bexley has the highest *rate* of part-time employment in London. Male employment *rate* s in Bexley have shown a big fall compared to rates in London.

Life expectancy in Bexley is higher than the national and regional average. It is particularly higher in the *ward* s Blackfen and Lamorbey for males and Danson Park for females.
The lowest life expectancy for men is in the Thamesmead East ward which is significantly lower than Blackfen and Lamorbey with the highest life expectancy for men. The difference in life expectancy of men in the most deprived and least deprived decile in 2004-08 was 7.8 years. Over the years, life expectancy in men in all deprivation deciles has improved. However in some areas of higher deprivation life expectancy in men has not had the same effect, particularly in decile 4 where life expectancy has actually decreased.

The lowest life expectancy for females is in the Colyers ward which is significantly different to the life expectancy in the Danson Park ward. There is a difference in life expectancy of women in the most deprived and least deprived decile in 2004-08 of 4.7 years. Life expectancy in females over the years, has in general improved, however this is not the case for deprivation decile 5 and 8.

Mortality from all causes in both females and males has decreased over the years and is one of the lowest in South East London. Mortality from all causes for people in Bexley is highest in the North End ward which is significantly higher than the mortality rate in the St. Mary's ward where mortality rate is the lowest. The top five causes of death are cancers, ischemic heart diseases, respiratory diseases, other circulatory diseases and digestive diseases.

Mortality for both cancer and chronic obstructive pulmonary disease (COPD) are higher in people living in more deprived areas: there is a correlation between cancer and COPD mortality and deprivation.

Cardiovascular diseases continue to be part of the major causes of death in Bexley. Prevalence of stroke and transient ischemic attacks in Bexley is highest in South East London after Bromley; prevalence in Bexley is significantly higher than prevalence of stroke and transient ischemic attacks in London. Just over 80 per cent of all strokes occur in people aged 64 and over. Men are more at risk of stroke than women. About 25 per cent of all men and 20 per cent of all women will experience a stroke if they reach the age of 85. Coronary Obstructive Pulmonary Disease (COPD) accounts for more time off work than any other illness. An exacerbation of COPD is one of the most common reasons for admission to hospital with 1 in 8 admissions due to COPD. One in six people in the working adult population (18-64) will suffer from mental health problems, including depression, phobia, obsessive compulsive disorder, panic disorder, generalised anxiety disorder, and mixed anxiety & depressive disorder . In Bexley, this would equate to 21,333 people.

Of all London CTs, Bexley has the third highest proportion of the population aged 65+, and the second highest estimated prevalence of late onset dementia (73 – 76.5 / 1000).

Conceptions in under 18s is reducing in Bexley. The rate per 1000 females aged 15-17 is down from 36.9 in 2006 to 28.4 in 2011.

Bexley has award winning services in cardiology and diabetes helping to address the needs and choices of Bexley residents. People with diabetes in Bexley achieve the best HbA1c in London with 60% of that population recording HbA1c <7% (per QOF DM23). This compares to an average for London of 52%.

According to the Health Profile for Bexley 2012, adult prevalence of obesity is 26.4% which is significantly worse than the England average of 24.2%. Bexley's prevalence of obesity in adults is also higher than the London average.

Results from the National Child Measurement programme for the school years 2010-11 show that in reception year the prevalence of obesity is 11.2% which is similar to that of London and higher than England. Also in reception year the prevalence of children who are overweight at 14.5% is higher than both the London and England.

3) Bexley Care Trust 2012/13 Performance against Statutory Financial Duties

In line with other NHS bodies, the Care Trust Accounts are prepared under the Government Resource Accounting and Budgeting (RAB) framework and is required by statute to meet certain financial duties to ensure that public funds are used appropriately. The Care Trust has Resource Limits for revenue and capital, and a cash limit. As the Government is effectively the main source of funding, the Income and Expenditure statement for example is replaced by an Operating Cost Statement, which reflects the Trust's net expenditure.

The Care Trust is required by statute to meet certain financial and administrative duties. These duties are:

(i) keep revenue spending within revenue resource limit (RRL) and achieve operational balance
(ii) keep capital spending within capital resource limit (CRL)
(iii) keep cash drawings within cash limit

In 2012/13 Bexley Care Trust achieved in full its statutory financial duties as follows:

(i) Keep spending within RRL and achieve operational balance

BCT underspent against its 2012/13 Revenue Resource Limit by £3,580,000 (0.95%) (note 3.1).

(ii) Keep spending within CRL

BCT underspent against its 2011/12 Capital Resource Limit by £9,000 (0.76%) (note 3.2).

(iii) Keep drawings within cash limit

Bexley Care Trust under-drew its 2012/13 Cash Limit by £10,500,000 and therefore managed within the maximum cash balance determined by the Department of Health as at 31 March 2013. The under-drawing was primarily due to the large continuing healthcare provision and 2012/13 surplus.

The following table shows the 2012/13 outturn position for Bexley Care Trust against its 2012/13 Resource Limits:

	Revenue Resource Limit	Capital Resource Limit	Total
	£000	£000	£000
Resource Limits 2012/13	378,784	1,185	379,969
Charge against Resource Limit	375,267	1,176	376,443
Underspend	3,517	9	3,526
% Underspend	0.93%	0.76%	0.93%

CTs recurring revenue allocations are normally rolled forward each year and adjusted for a national uplift and a movement towards a target allocation, based on the national weighted capitation formula. The capitation formula weights census-based actual population (registered with a GP in each CT's area) according to a wide range of healthcare related factors. The result is a "fair share" or target allocation and CTs under target receive a greater uplift; CTs over target receive a smaller uplift.

Under the Department of Health year-end carry forward arrangements Revenue Resource Limit underspends reported at Month 12 2012/13 will be recovered by CCGs in 2013/14 in proportion to the allocation received. Underspends against Capital Resource Limits are not carried forward. PCTs & CCGs bid for capital resources on an annual basis.

The Care Trust has revalued its land and buildings as at 31/03/2012 in order to comply with IFRS accounting requirements

International Financial Reporting Standards

International Financial Reporting Standards (IFRS) are accounting standards issued by the International Accounting Standards Board (IASB). The Chancellor's 2007 Budget announced that the accounts of central government departments and entities in the wider public sector will be produced using IFRS, as interpreted for the public sector in the IFRS-based Financial Reporting Manual (FReM). Central government, NHS Trusts, Primary Care Trusts and NHS Foundation Trusts would all need to adopt IFRS and the annual accounts for government organisations and the NHS prepared using IFRS standards. In addition, comparative financial information for the prior year was restated along with opening balances. IFRS has been implemented across the NHS from 2009/10.

Use of Resources Assessment / Value for Money Review

In 2010/11 the previous Use of Resources assessment was replaced by the Audit Commission after a review of its approach to auditor's work to ensure that it is more targeted and gives better value. For 2012/13, Auditors are giving their statutory Value for Money (VFM) conclusion on the arrangements to secure economy, efficiency and effectiveness based on two criteria:

(i) securing financial resilience - focusing on whether the CT is managing its financial risks to secure a stable financial position for the foreseeable future

(ii) challenging how it secures economy, efficiency and effectiveness - focusing on whether the CT is prioritising its resources within tighter budgets and improving productivity and efficiency.

This has been the subject of VFM Review by external audit during 2012/13. The Review has also taken account of the significant demands placed on the NHS as a result of the transition towards implementation of the white paper *Equity and Excellence : Liberating the NHS*

Counter Fraud & Corruption

The CT has an agreed Counter Fraud Strategy in place in support of the CT's Counter Fraud and Corruption Policy. The Strategy ensures that all involved in both the provision and use of the services are engaged in countering fraud and corruption. The importance of counter fraud is embedded across the organisation by training and communications including posters, e-mails and payslip attachments. The CT's Counter Fraud activities are informed by best practice guidance provided by the Counter Fraud and Security Management Service (CFSMS) in accordance with the Secretary of State Directions.

4) Corporate Governance

The Care Trust has in place corporate governance arrangements that have been approved by the Joint Boards in 2011 and are set out in the Corporate Governance and Accountability Framework. This includes detailed Standing Orders and Standing Financial Instructions. During 2012/13 the PCT Cluster Board has kept its governance arrangements under review to ensure that they remain fit for purpose and have made a number of changes to the subcommittee structure.

There is an established Board Assurance Framework and supporting risk register in place as part of our regular integrated Performance and Reporting Framework built upon our annual business plan objectives.

From 1st October 2011, the BSU received budgetary delegation for all budgets, with the exception of primary care. These were managed jointly with NHSSEL, with ultimate accountability, by the Clinical Cabinet. This Cabinet includes GPs, Non-Executive Directors and Senior BSU managers, and reports directly to the Joint Board.

The Care Trust has in place a Board Assurance Framework which has been developed over recent years in line with best practice. A Risk Management Strategy is in place, alongside a supporting risk framework and risk register.

5) Developments during 2011/12

Equity and Excellence: Liberating the NHS

The government published its White Paper, Equity and Excellence: Liberating the NHS in July 2010, setting out its long-term vision for the future of the NHS. The White Paper set out how the government intends to put patients at the heart of everything the NHS does, focus on continuously improving those things that really matter to patients - the quality and outcome of their healthcare and empower and liberate clinicians to innovate, with the freedom to focus on improving healthcare services. This has now been passed into legislation and is awaiting Royal Assent.

For PCTs the key proposals include:

- Commissioning - the transfer of Commissioning responsibility from PCTs to GP Commissioning consortia, leading to the abolition of Strategic Health Authorities (SHAs) and PCTs and the creation of an NHS Commissioning Board.

- Public Health and wellbeing: including the creation of a Public Health service and the transfer of Health improvement functions to local government

- Resources: the government has restated its commitment to real terms increases in funds for health, to the need for the NHS to deliver £20 billion efficiency savings and the reduction in NHS management costs by 45 per cent over the next four years.

It is intended that commissioning needs to be outward facing with commissioners drawing on patients, the public, clinicians, partners and staff to share new patterns of care and develop longer term system-wide solutions to the QIPP challenge. The new system will involve developing an integrated commissioning system with the establishment of the National Commissioning Board, GP consortia pathfinders and early implementer Health and Wellbeing Boards. The new system will be supported by key enablers in patient information, empowerment and choice, informatics, education and training, public health and human resources and the national approach to development in these areas.

Practice Based Commissioning and Clinical Commissioning

The Care Trust has worked closely with GPs for several years. During 2010/11, the Board approved the formation of a Clinical Cabinet to take on day to day responsibility for commissioning. An election process was undertaken in December 2010 to enable GPs to elect representatives from the three Bexley localities, a chair and a salaried GP representative.

The Care Trust has been working with GPs to move from Practice Based Commissioning to develop GP Commissioning following the White Paper of July 2010. GP commissioners in Bexley work in three localities. Each locality has a lead GP and meets regularly to inform commissioning. The Clinical Cabinet GP members were nominated and elected in November 2010 with delegated authority from the Care Trust Board to ensure GP commissioning input into the in-year performance issues. During 2012/13, this group has worked as a Committee of the Care Trust/Joint Board and developed the Strategic Plan and assisted in developing the QIPP programme. We have worked with GPs to develop, commission and review new care pathways and further develop practice based reporting. GPs continue to use the MEDE system which allows desk top access to review all patient acute pathways and treatment. Further elections took place during 2011/12 to elect a further three GP Clinical Cabinet representative, one from each of the three localities.

Payment by Results, CQUIN and Quality Accounts

In 2012/13, there have continued to be developments in the NHS Payments by Results (PbR) system. Under this national system there is a standard price tariff by which provider trusts are funded for activity undertaken on behalf of CT populations. The structure of national tariffs in the acute sector has been revised from 2009/10 following the introduction of new national contract currencies including best practice tariffs. Developments in mental health PbR continues with full implementation now expected in 2014/15.

The Commissioning for Quality and Innovation (CQUIN) payment framework introduced in 2009/10, has continued in 2012/13. This is linked to quality improvement goals set out in provider contracts reflecting national, regional and local priorities. The publication of quality performance information within annual Quality Accounts was a requirement from April 2010 for acute and mental healthcare providers delivering services on behalf of the NHS.

Health & Well Being Board
In anticipation of the expected Public Health bill, where responsibility for Public Health could transfer to Local Authorities, a Shadow Health & Wellbeing Board, with members from both the Care Trust and London Borough of Bexley (LBB) was formed during 2010-11. The Board is chaired by the Lead of Bexley Council.

The finances to be transferred to LBB to support this function have now been agreed.

Cluster Working and Disestablishment of PCTs

In preparation for the disestablishment of PCTs on 31st March 2013, and transfer of responsibility for healthcare resources to GP Commissioning Consortia, NHS South East London was formed. South East London was one of the first areas to establish this way of working. The cluster consisted of a single Board and management team across all six South East London Primary Care Trusts/Care Trusts, including Bexley. From 1st April 2011, South East London had a single Accountable Officer and Director of Finance. Bexley Care Trust remained the statutory body until March 31st 2013.

On 16 July 2012, the Secretary of State for Health appointed a Trust Special Administrator (TSA) to South London Healthcare Trust under the Regime for Unsustainable NHS Providers (UPR). He was appointed to make recommendations on how to deliver a lasting clinical and financial solution for the Trust. Following a period of consultation, the Secretary of State broadly accepted the recommendations in the TSA's final report as follows:

- Lewisham Hospital to retain it's A&E
- South London Healthcare Trust to be dissolved, with each of its hospitals being taken over by a neighbouring hospital Trust (subject to the approval of relevant regulators)
- All three hospitals within South London Healthcare NHS Trust - Queen Elizabeth Hospital in Woolwich, Queen Mary's in Sidcup and the Princess Royal in Bromley to make the full £74.9m of efficiencies identified by the Trust Special Administrator.
- All vacant or poorly utilised premises to be vacated and sold where possible.
- The Department of Health to pay for the excess costs of the PFI buildings at the Queen Elizabeth and Princess Royal Hospitals and write off the accumulated debt of the Trust so that the new organisations are not saddled with historic debts. It will also provide an appropriate level of transitional funding to cover planning and subsequent implementation.

The impact of these changes continues to be assessed with Commissioners to ensure that the impact of the required financial improvement is delivered in a manner to maintain quality services in the most appropriate environment for patients.

For more detailed information please visit http://www.tsa.nhs.uk/document-folders/final-report

Queen Mary's Hospital Sidcup

During 2010/11, A&E and maternity services were closed at the Queen Mary's site of the South London Healthcare NHS Trust, in line with approved proposals in 'A Picture of Health'. Bexley Care Trust, in close collaboration with GPs, The London Borough of Bexley, South London Healthcare NHS Trust and Oxleas NHS Foundation Trust have prepared a detailed proposal for services to be provided at the site as a Healthcare Campus, to provide local services to residents and secure the future of the site. This proposal was included as part of the Trust Special Administrator work across South London Healthcare Trust and South East London, and accepted for implementation.

Joint Working with Local Authority

During 2011/12, the Care Trust successfully co-located Public Health staff to mirror future arrangements anticipated in the Public Health bill. Work on the financial elements of the transfer was finalised during 2012/13. A Joint Commissioning Unit between the Care Trust and the Local Authority has now been formed, to ensure joined up commissioning and more effective and efficient use of resources. This work will also continue in the next financial year with the CCG.

NHS Connecting for Health

Bexley Care Trust successfully rolled out Rio 5.1 during 2012/13.

6) Future developments

Queen Mary's Sidcup Campus

Further work will continue on the Healthcare Campus proposals for the Queen Mary's Sidcup site to assess their feasibility and affordability during 2012/13. This will include the continued close collaboration with Bexley Care Trust's key partners.

Joint Working with Local Authority
During 2012/13, the Care Trust continued to progress joint working on Public Health and the Joint Commissioning Unit and will be looking at further ways of working jointly with the London Borough of Bexley, in order to work more efficiently and potentially make efficiency gains.

Clinical Commissioning Group (CCG) Authorisation
The Bexley Clinical Cabinet worked closely with NHS South East London and NHS London to gain CCG authorisation before 31st March 2013, including the development of a local structure to ensure delivery of all statutory duties and remain within the required £25 per head running costs. The first stage was to ensure delegation of full budgets during 2012/13.

Commissioning Support Services (CSS)
During 2011/12, Bexley Care Trust continued to work with the NHS South East London to develop the CSS. This was an organisation delivering some support services across South East London, thus realising efficiency savings and assist in delivering Operating Costs within the required £25 per head.

Bexley Care Trust Strategic Plan 2010/11 to 2014/15

The 2010-15 Strategic Plan was developed at South East London Sector level based on detailed input at Bexley borough level. The local Bexley plan builds on the work undertaken during 2009/10 through a systematic prioritisation exercise working with local partners and stakeholders to agree priority health goals, associated delivery initiatives and outcome measures. The production of the 2010-15 Strategy included developing a five year Quality, Innovation, Productivity and Prevention (QIPP) Strategy. During 2011/12 Bexley reviewed its priority health goals and re-affirmed these as being long-term conditions, mental illness, sexual health and child health. McKinsey and Company worked with the Care trust to develop significant QIPP opportunities which were further developed during 2012/13.

The Strategic Plan can be accessed at the Bexley Care Trust - **www.bexley.nhs.uk.**

STATEMENT OF THE RESPONSIBILITIES OF THE SIGNING OFFICER OF THE PRIMARY CARE TRUST 2012-13 ACCOUNTS

The Department of Health's Accounting Officer has designated the role of signing officer for the final accounts of Bexley Care Trust to discharge the following responsibilities for the Department of Health:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to the primary care trust;

- the expenditure and income of the primary care trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are in place; and

- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the net operating cost, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, and from the assurances provided by the PCT Accountable Officer until 31 March 2013, I am assured that the responsibilities have been properly discharged.

Signed...

Date........................

Carl Vincent
Director of Provider Finance and Finance Transition

2012/13 Accounts Certificate of Assurance to the Department of Health Director General, Strategy Finance and NHS

I am aware that as signing officer designated by the Department of Health Accounting Officer, you are required to sign the accounts and supporting certificates of Bexley Care Trust (CT) in order to comply with the Department's 2012/13 accounts finalisation process.

To assist you in that process, I can confirm that for the year ended 31 March 2013 based on my own knowledge of internal control matters and through experience in my role as Accountable Officer until 31 March 2013, the CT:

- had in place effective management systems to safeguard public funds and assets and assist in the implementation of corporate governance;
- kept proper accounting records which disclosed with reasonable accuracy at any time the financial position
- took reasonable steps for the prevention and detection of fraud and other irregularities;
- achieved value for money from the resources available to the CT;
- applied income and expenditure to the purposes intended by Parliament and conformed to the authorities which governed them; and
- had effective and sound financial management systems in place.

I also confirm that in my role overseeing the preparation of the annual statutory accounts, the accounts were prepared in the format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the net operating cost, recognised gains and losses and cash flows for the year. As required the accounts;

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

Andrew Kenworthy
Accountable Officer 2012/13

Signature:

Date: 24 April 2013

2012/13 Accounts Certificate of Financial Assurance to the Department of Health Director Strategy Finance and NHS

I am aware that as signing officer designated by the Department of Health Accounting Officer, you are required to sign the accounts and supporting certificates of Bexley Care Trust (CT) in order to comply with the Department's 2012/13 accounts finalisation process.

To assist you in that process, I can confirm that in my role managing the preparation of the annual statutory accounts, the accounts were prepared in the format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the net operating cost, recognised gains and losses and cash flows for the year. As required the accounts:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

Richard Chapman
Director of Finance SEL Cluster 2012/13

Signature:

Date: 24 April 2013

INDEPENDENT AUDITOR'S REPORT TO THE DEPARTMENT OF HEALTH'S ACCOUNTING OFFICER IN RESPECT OF BEXLEY CARE TRUST

We have audited the financial statements of Bexley Care Trust for the year ended 31 March 2013 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

We have also audited the information in the Remuneration Report that is subject to audit, being:

- the tables of salaries and allowances of senior managers and related narrative notes;
- the tables of pension benefits of senior managers and related narrative notes; and.
- the pay multiples disclosure and related narrative notes.

This report is made solely to the Department of Health's Accounting Officer in respect of Bexley Care Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Department of Health's Accounting Officer and the Trust as a body, for our audit work, for this report, or for opinions we have formed.

Respective responsibilities of the Signing Officer and auditor

As explained more fully in the Accounts Certificate of Assurance to the Department of Health Director General, Strategy, Finance and NHS, the Signing Officer is responsible for overseeing the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

In addition, we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income reported in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on regularity

In our opinion, in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Bexley Care Trust as at 31 March 2013 and of its net operating costs for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In our opinion:

- the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We report to you if:

- in our opinion the governance statement does not reflect compliance with the Department of Health's Guidance;
- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.

Other matters on which we are required to conclude

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are also required by the Audit Commission's Code of Audit Practice to report any matters that prevent us being satisfied that the audited body has put in place such arrangements.

We have undertaken our audit in accordance with the Code of Audit Practice and, having regard to the guidance issued by the Audit Commission, we have considered the results of the following:

- our review of the annual governance statement;
- the work of other relevant regulatory bodies or inspectorates, to the extent the results of the work have an impact on our responsibilities; and
- our locally determined risk-based work on transition arrangements.

As a result, we have concluded that there are no matters to report.

Certificate

We certify that we have completed the audit of the financial statements of Bexley Care Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Susan M Exton
Senior Statutory Auditor, for and on behalf of Grant Thornton UK LLP

Grant Thornton House
Melton Street
Euston Square
London
NW1 2EP

5 June 2013

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure			
Gross employee benefits	7.1	5,813	4,388
Other costs	5.1	376,213	355,332
Income	4	(6,842)	(5,623)
Net operating costs before interest		375,184	354,097
Investment income	9	(177)	(59)
Finance costs	10	260	411
Net operating costs for the financial year		375,267	354,449
Transfers by absorption -(gains)		0	0
Transfers by absorption - losses		0	0
Net (gain)/loss on transfers by absorption		0	0
Net Operating Costs for the Financial Year including absorption transfers		375,267	354,449
Of which:			
Administration Costs			
Gross employee benefits	7.1	2,969	2,757
Other costs	5.1	3,685	4,232
Income	4	(341)	(359)
Net administration costs before interest		6,313	6,630
Investment income	9	(177)	0
Finance costs	10	0	0
Net administration costs for the financial year		6,136	6,630
Programme Expenditure			
Gross employee benefits	7.1	2,844	1,631
Other costs	5.1	372,528	351,100
Income	4	(6,501)	(5,264)
Net programme expenditure before interest		368,871	347,467
Investment income	9	0	(59)
Finance costs	10	260	411
Net programme expenditure for the financial year		369,131	347,819

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	1,402	787
Net (gain) on revaluation of property, plant & equipment	(432)	(858)
Total comprehensive net expenditure for the year*	376,237	354,378

The notes on pages 18 to 54 form part of this account.

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	11.1	17,145	17,717
Other financial assets	17.1	289	158
Trade and other receivables	15.1	152	151
Total non-current assets		17,586	18,026
Current assets:			
Trade and other receivables	15.1	2,972	6,018
Cash and cash equivalents	18	302	1
Total current assets		3,274	6,019
Total current assets		3,274	6,019
Total assets		20,860	24,045
Current liabilities			
Trade and other payables	19	(23,913)	(22,182)
Provisions	21	(4,685)	(145)
Borrowings	20	(163)	(134)
Total current liabilities		(28,761)	(22,461)
Non-current assets plus/less net current assets/liabilities		(7,901)	1,585
Non-current liabilities			
Provisions	21	(2,632)	(338)
Borrowings	20	(4,309)	(4,473)
Total non-current liabilities		(6,941)	(4,811)
Total Assets Employed:		(14,842)	(3,227)
Financed by taxpayers' equity:			
General fund		(19,181)	(8,535)
Revaluation reserve		4,338	5,308
Total taxpayers' equity:		(14,842)	(3,227)

The notes on pages 18 to 54 form part of this account.

The financial statements on pages *14 to 17* were approved by the DH Audit Committee on 31 May 2013 and signed on its behalf by

Carl Vincent
Director of Provider Finance and Finance Transition

Date: 31/5/13

Statement of Changes In Taxpayers Equity for the year ended 31 March 2013

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2012	**(8,535)**	**5,308**	**0**	**(3,227)**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(375,267)			**(375,267)**
Net gain on revaluation of property, plant, equipment		432		**432**
Impairments and reversals		(1,402)		**(1,402)**
Reclassification Adjustments				
Total recognised income and expense for 2012-13	**(375,267)**	**(970)**	**0**	**(376,237)**
Net Parliamentary funding	364,621			**364,621**
Balance at 31 March 2013	**(19,181)**	**4,338**	**0**	**(14,842)**
Balance at 1 April 2011	**(10,049)**	**4450**	**0**	**(5,599)**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(354,449)			(354,449)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment		1,645		1,645
Impairments and Reversals		(787)		(787)
Total recognised income and expense for 2011-12	(354,449)	858	0	(353,591)
Net Parliamentary funding	355,963			355,963
Balance at 31 March 2012	**(8,535)**	**5,308**	**0**	**(3,227)**

Statement of cash flows for the year ended 31 March 2013

	2012-13	2011-12
	£000	£000
Cash Flows from Operating Activities		
Net Operating Cost Before Interest	(375,184)	(354,097)
Depreciation and Amortisation	778	1,018
Impairments and Reversals	0	94
Interest Paid	(260)	(402)
(Increase)/Decrease in Trade and Other Receivables	3,089	(4,012)
Increase/(Decrease) in Trade and Other Payables	1,731	1,642
Provisions Utilised	(350)	(148)
Increase/(Decrease) in Provisions	7,183	124
Net Cash Inflow/(Outflow) from Operating Activities	(363,012)	(355,781)
Cash flows from investing activities		
Interest Received	178	59
(Payments) for Property, Plant and Equipment	(1,220)	(133)
(Payments) for Other Financial Assets	(131)	0
(Payments) for Financial Assets (LIFT)	0	(7)
Net Cash Inflow/(Outflow) from Investing Activities	(1,173)	(81)
Net cash inflow/(outflow) before financing	(364,185)	(355,862)
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP LIFT	(135)	(134)
Net Parliamentary Funding	364,621	355,963
Net Cash Inflow/(Outflow) from Financing Activities	364,486	355,829
Net increase/(decrease) in cash and cash equivalents	301	(33)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	1	34
Cash and Cash Equivalents (and Bank Overdraft) at year end	302	1

1. Accounting policies

The Secretary of State for Health has directed that the financial statements of PCTs shall meet the accounting requirements of the PCT Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2012-13 PCTs Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the PCT Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the PCT for the purpose of giving a true and fair view has been selected. The particular policies adopted by the PCT are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

The PCT is within the Government Resource Accounting Boundary and therefore has only consolidated interests in other entities where the other entity is also within the resource accounting boundary and the PCT exercises in-year budgetary control over the other entity.

In accordance with the directed accounting policy from the Secretary of State, the PCT does not consolidate the NHS charitable funds for which it is the corporate trustee.

Under the provisions of The Health and Social Care Act 2012 (Commencement No.4. Transitional, Savings and Transitory Provisions) Order 2013, Bexley Care Trust was dissolved on 1st April 2013. The Care Trust's functions, assets and liabilities transferred to other public sector entities as outlined in Note 28 Events after the Reporting Period. Where reconfigurations of this nature take place within the public sector, Government accounting requires that the activities concerned are to be considered as continuing operations, and so the closing entity prepares accounts on a "going concern" basis.

The SOFP has therefore been drawn up at 31 March 2013 on the same basis as in previous years, reporting balances on the same basis as would a continuing entity. In particular, there has been no general revaluation of assets or liabilities, and no disclosures have been made under IFRS 5 Non-current Assets Held for Sale and Discontinued Operation.

1.1 Accounting Conventions

The financial statements have been prepared in accordance with EU endorsed International Financial Reporting Standards and IFRIC's as applicable to the NHS under the FReM.

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities

Acquisitions and Discontinued Operations

Activities are considered to be 'acquired' only if they are acquired from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one NHS body to another.

1. Accounting policies (continued)

Critical accounting judgements and key sources of estimation uncertainty

In the application of the Care Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors, that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the entity's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Revenue recognition

Revenue is accounted for applying the accruals convention. Income is recognised in the period in which services are provided. Where revenue has been received for a specific activity to be delivered in the following financial year, that revenue will be deferred.

Expenditure related to partially completed contracts for patient services are not accounted for as work-in-progress but expenditure is accrued in respect of part-completed treatment episodes at the statement of financial position

Classification of property

The Care Trust owns a number of properties, which are maintained primarily to provide services. The receipt of market-based rental from these properties is incidental to holding these properties. These properties are held for service delivery objectives as part of the Care Trust's Community Strategy Plan and Strategic Services Development Plan. These properties are accounted for as property, plant and equipment

LIFT

The PCT's accounting policies regarding its LIFT scheme are disclosed in Note 1.22 to these financial statements. The PCT accounts for these assets under IFRIC 12 as a service concession and when the applicable elements of IAS 17 are met these are capitalised.

The Care Trust initially recognised the LIFT assets and associated finance lease liability at the assets' fair value. The PCT's LIFT asset is being accounted for in two ways, an element as if it was a freehold building and an element as plant and equipment, the accounting judgements and estimation uncertainty for both of which are disclosed below. The PCT has taken the judgement that, due to the uncertainty over the size and structure of the health care economy at the end of the lease, it is unlikely that it will exercise its repurchase option over the LIFT at the end of the lease life. It is therefore depreciating the asset over the life of the lease rather than the asset's useful economic life. The LIFT finance lease liabilities are being amortised over the lives of the lease using the rate of return required by the assets' operators. This rate has been estimated using the assets' operators' financial models, as agreed with the PCT at the schemes' inception, and is estimated to spread that return over the life of the leases.

As part of the Care Trust's LIFT contract, the LIFT operator provides a Managed Equipment Service ('MES'). Through this service the Care Trust has access to a wide range of equipment within the scheme, and these assets are maintained and replaced at the end of their useful economic life by the LIFT operator. This Care Trust has judged that these assets should be held as plant and equipment and therefore, in line with the Care Trust's accounting policies, depreciated over 5 years. Deferred income has been set up to smooth tenant's income in relation the MES element of the LIFT unitary payment to the MES costs over time.

The Care Trust recognises the fact that the financial models employed to account for the LIFT scheme profile the capital additions and capital lease payments on a changeable basis each year, which causes considerable variations in the rental costs taken to the Statement of Comprehensive Net Expenditure from year to year. Subsequent rental charges for the LIFT properties to the Care Trust's tenants are conversely calculated on a basis which allows a more comparable and predictable charge year on year and smoothes the affect of these variations. The difference between the rental charge to tenants and the charge to the income statement relating to that rental charge is a timing difference and is accounted for as either deferred or accrued income in the year.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments.

1. Accounting policies (continued)

Provisions

The significant critical judgments for the Care Trust's pension provisions are disclosed in Note 7.5

Redundancy Payment Accruals and Provisions – Care Trust Reorganisation : The accounts include accruals for redundancies that incurred during March 2013. Number of payments for these redundancies were made in March 2013 and reported as cash expenditure. Payments for redundancies due and not paid have been accrued

Property, plant, and equipment

The Care Trust's accounting judgments around its property, plant, and equipment base are the residual lives and value of the Care trust assets, which impact the annual depreciation charge and therefore holding amount of the asset, the methodology used to ensure the assets holding amount reflect current cost, particularly around its land and buildings and the application of indexation, and the timing of when asset are capitalised (brought into use) and derecognised (and moved to assets held for resale and to be disposed of).

The Care Trust recognises leases when in the judgement of the board the transaction meets the definition of a lease as set down by IAS 17 or transactions where there is no formal lease but where there is a substance of a lease as require by IFRIC 4. The PCT will decide on whether to recognise leases as finance or operating leases using the criteria laid down by IAS 17 with a rebuttable presumption that leases where the net present of future lease payments exceeds 90% of the asset's fair value at the inception of the lease the lease will be capitalised as a finance lease. Where other factors suggest a finance lease category better reflects the substance of the transaction and the transfer of risks and rewards of the leased asset the PCT will capitalise the lease even if the

Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

The Care Trust has exercised its judgement on the appropriate classification of building leases and has determined a number of lease arrangements are finance leases.

Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the Statement of Financial Position date, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year

Recoverability of NHS debtors

The Care Trust does not provide against amounts due from other NHS bodies and is not aware of disputes or any other factors that could have impact on recoverability of those debts.

Provisions

The significant estimation uncertainties for the Care Trust's continuing care provisions are disclosed in Note 21

The Care Trust has no other material provisions. The Care Trust is of the judgement that there is no material estimation uncertainty over the completeness of its provisions.

Property, plant, and equipment

The Care Trust's estimates regarding property, plant, and equipment used are disclosed in Note 1.6. They are annually reviewed by the Care Trust, using external specialist advice where appropriate. Where there is indication that the Care Trust's assets are impaired, the estimation technique used to calculate the level of impairment is to compare the current holding amount of the asset to the assets fair value as derived by a professional valuer and using a valuation basis suitable for the asset (normally open market value for alternative use). The difference is then accounted for in line with the applicable accounting standards.

1. Accounting policies (continued)

1.2 Revenue and Funding

The main source of funding for the Care Trust is allocations (Parliamentary Funding) from the Department of Health within an approved cash limit, which is credited to the General Fund of the Primary Care Trust. Parliamentary funding is recognised in the financial period in which the cash is received.

Miscellaneous revenue is income which relates directly to the operating activities of the Care Trust. It principally comprises fees and charges for services provided on a full cost basis to external customers, as well as public repayment work. It includes both income appropriated-in-aid of the Vote and income to the Consolidated Fund which HM Treasury has agreed should be treated as operating income.

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where revenue has been received for a specific activity to be delivered in the following financial year, that income will be deferred.

1.3 Taxation

The Care Trust is not liable to pay corporation tax. Expenditure is shown net of recoverable VAT. Irrecoverable VAT is charged to the most appropriate expenditure heading or capitalised if it relates to an asset.

1.4 Administration and Programme Costs

Treasury has set performance targets in respect of non-frontline expenditure (administration expenditure).
From 2011-12, Care Trusts therefore analyse and report revenue income and expenditure by "admin and programme"
For Care Trusts, the Department has defined "admin and programme" in terms of running costs.

The broad definition of running costs includes any cost incurred that is not a direct payment for the provision of healthcare or healthcare related services.
Expense incurred under NHS transition redundancy programmes is however classed as "programme" under Treasury budgetary control arrangements and so is recorded as such in the financial statements.

1.5 Care Trust Designation

Bexley Care Trust is a Primary Care Trust that is designated by the Secretary of State under s45 of the Health and Social Care Act 2001 as a Care Trust. With effect from 1 April 2009 functions transferred back to the London Borough of Bexley. Bexley Care Trust retains its status as a Care Trust. Bexley Care Trust ceases to exit on 01 April

1. Accounting policies (continued)

1.6 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Care Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the Care Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive net expenditure in the Statement of Comprehensive Net Expenditure

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1. Accounting policies (continued)

1.7 Depreciation, amortisation and impairments

Freehold land, properties under construction are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Care Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Care Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives

At each reporting period end, the Care Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME) from 2011-12. This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.
AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury

1. Accounting policies (continued)

1.8 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Care Trust's cash management.

1.9 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings including losses which would have been made good through insurance cover had Care Trust's not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.10 Clinical Negligence Costs

From 1 April 2000, the NHS Litigation Authority (NHSLA) took over the full financial responsibility for all Existing Liabilities Scheme (ELS) cases unsettled at that date and from 1 April 2002 all Clinical Negligence Scheme for Trusts (CNST) cases. Provisions for these are included in the accounts of the NHSLA. Although the NHSLA is administratively responsible for all cases from 1 April 2000, the legal liability remains with the Care Trusts.

The NHSLA operates a risk pooling scheme under which the Care Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure in the year that it is due. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Care Trust is disclosed at Note 21.

1. Accounting policies (continued)

1.11 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, except for bonuses earned but not yet taken which, on the grounds of immateriality.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the CT commits itself to the retirement, regardless of the method of payment.

1.12 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.13 Grant making

Under section 256 of the National Health Service Act 2006, the Care Trust has the power to make grants to local authorities, voluntary bodies and registered social landlords to finance capital or revenue schemes. A liability in respect of these grants is recognised when the CT has a present legal or constructive obligation which occurs when all of the conditions attached to the payment have been met.

1. Accounting policies (continued)

1.14 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Care Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.15 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Care Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Care Trust's net operating cost.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The Care Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Care Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Care Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.16 Provisions

Provisions are recognised when the Care Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Care Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% (2.8% in respect of early staff departures) in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Care Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Care Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arsing from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1. Accounting policies (continued)

1.17 Financial Instruments

Financial assets

Financial assets are recognised when the Care Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories: financial assets 'at fair value through profit and loss'; 'held to maturity investments'; 'available for sale' financial assets, and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss

Bexley Care Trust has reviewed its contracts and determined that it does not hold any contracts with embedded deriva

Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective

Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the Statement of Comprehensive Net Expenditure on de-recognition. Fair value is determined by the

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the Statement of Financial Position date, the Care Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Net Expenditure and the carrying amount of the asset is reduced directly, or through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the Statement of Comprehensive Net Expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1. Accounting policies (continued)

Financial liabilities
Financial liabilities are recognised on the Statement of Financial Position when the Care Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are derecognised when the liability has been discharged, that is, the liability has

Financial liabilities are initially recognised at fair value.

Financial liabilities are classified as either financial liabilities 'at fair value through profit and loss' or other financial

Financial liabilities at fair value through profit and loss
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Statement of Comprehensive Net Expenditure. The net gain or loss incorporates any interest earned on the financial asset.

Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest

1.18 NHS LIFT transactions

HM Treasury has determined that government bodies shall account for infrastructure LIFT schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Care Trust therefore recognises the LIFT asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the LIFT asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

a) Services received
The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

b) LIFT assets, liabilities, and finance costs
The LIFT assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Care Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

A LIFT liability is recognised at the same time as the LIFT assets are recognised. It is measured initially at the same amount as the fair value of the LIFT assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

1. Accounting policies (continued)

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Net Expenditure.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

c) Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Care Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Care Trust to the operator for use in the scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Care Trust's Statement of Comprehensive Net Expenditure.

Other assets contributed by the Care Trust to the operator
brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Care Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.19 Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2012-13. The application of the Standards as revised would not have a material impact on the accounts for 2012-13, were they applied in that year:

IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 9 Financial Instruments - subject to consultation - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation

2 Operating segments

Provider services transferred to Oxleas NHS Foundation Trust and South London Healthcare NHS Trust on 1st April 2011, therefore Bexley Care Trust no longer has another operating segment.

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCTs' performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year		
Net operating cost plus (gain)/loss on transfers by absorption	375,267	354,449
Revenue Resource Limit	378,784	356,723
Under/(Over)spend Against Revenue Resource Limit (RRL)	**3,517**	2,274

3.2 Capital Resource Limit

The PCT is required to keep within its Capital Resource Limit.

	2012-13 £000	2011-12 £000
Capital Resource Limit	1,185	353
Charge to Capital Resource Limit	1,176	84
(Over)/Underspend Against CRL	**9**	**269**

3.3 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	364,621	355,963
Cash Limit	375,121	355,963
Under/(Over)spend Against Cash Limit	**10,500**	**0**

3.4 Reconciliation of Cash Drawings to Parliamentary Funding (current year)

	2012-13 £000
Total cash received from DH (Gross)	321,563
Sub total: net advances	**321,563**
Plus: cost of Dentistry Schemes (central charge to cash limits)	7,609
Plus: drugs reimbursement (central charge to cash limits)	35,449
Parliamentary funding credited to General Fund	**364,621**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Fees and Charges	**2**	0	2	3
Dental Charge income from Contractor-Led GDS & PDS	**2,323**		2,323	2,307
Prescription Charge income	**1,564**		1,564	1,508
Strategic Health Authorities	**101**	0	101	78
NHS Trusts	**59**	0	59	0
NHS Foundation Trusts	**1,090**	0	1,090	11
Primary Care Trusts - Other	**602**	125	477	492
Local Authorities	**108**	0	108	268
Education, Training and Research	**40**	40	0	21
Rental revenue from operating leases	**536**	0	536	533
Other revenue	**417**	176	241	402
Total miscellaneous revenue	**6,842**	**341**	**6,501**	**5,623**

5. Operating Costs

5.1 Analysis of operating costs:

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Goods and Services from Other PCTs				
Healthcare	**16,965**		16,965	11,994
Non-Healthcare	**1,644**	1,644	0	2,206
Total	**18,609**	**1,644**	**16,965**	**14,200**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**138,272**	91	138,181	133,568
Goods and services (other, excl Trusts, FT and PCT))	**5**	0	5	904
Total	**138,277**	**91**	**138,186**	**134,472**
Goods and Services from Foundation Trusts	**99,325**	176	99,149	95,876
Purchase of Healthcare from Non-NHS bodies	**31,266**	0	31,266	21,555
Expenditure on Drugs Action Teams	**384**	0	384	362
Non-GMS Services from GPs	**3,270**	0	3,270	3,057
Contractor Led GDS & PDS (excluding employee benefits)	**9,929**	0	9,929	9,992
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	**750**	0	750	744
Chair, Non-executive Directors & PEC remuneration	**32**	32	0	33
Executive committee members costs	**230**	230	0	111
Consultancy Services	**306**	0	306	793
Prescribing Costs	**30,267**	0	30,267	31,435
G/PMS, APMS and PCTMS (excluding employee benefits)	**28,544**	0	28,544	28,220
New Pharmacy Contract	**7,282**	0	7,282	7,255
General Ophthalmic Services	**1,915**	0	1,915	1,873
Supplies and Services - Clinical	**1,758**	0	1,758	1,816
Supplies and Services - General	**127**	25	102	60
Establishment	**459**	241	218	366
Transport	**1**	1	0	5
Premises	**1,754**	857	897	1,587
Impairments & Reversals of Property, plant and equipment	**0**	0	0	94
Depreciation	**778**	110	668	1,018
Impairment of Receivables	**(90)**	0	(90)	5
Audit Fees	**97**	97	0	149
Other Auditors Remuneration	**0**	0	0	92
Clinical Negligence Costs	**17**	0	17	13
Education and Training	**57**	32	25	93
Grants for capital purposes	**484**	0	484	0
Other	**385**	149	236	56
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**376,213**	**3,685**	**372,528**	**355,332**
Employee Benefits (excluding capitalised costs)				
PCT Officer Board Members	**414**	414	0	424
Other Employee Benefits	**5,399**	2,555	2,844	3,964
Total Employee Benefits charged to SOCNE	**5,813**	**2,969**	**2,844**	**4,388**
Total Operating Costs	**382,026**	**6,654**	**375,372**	**359,720**

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Analysis of grants reported in total operating costs				
For capital purposes				
Grants to Private Sector to Fund Capital Projects	**484**	0	484	0
Total Capital Grants	**484**	**0**	**484**	**0**
Total Grants	**484**	**0**	**484**	**0**

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**6,403**	5,888	515
Weighted population (number in units)*	**212,833**	212,833	212,833
Running costs per head of population (£ per head)	**30**	**28**	**2**
PCT Running Costs 2011-12			
Running costs (£000s)	**6,630**	6,113	517
Weighted population (number in units)	**212,833**	212,833	212,833
Running costs per head of population (£ per head)	**31**	**29**	**2**

* Weighted population figures are not available for 2012-13 as the weighted capitation formula for PCT allocations was not updated for 2012-13. This was because it was decided to give all PCTs the same percentage growth in their allocations in this transitional year rather than differential growth based on a weighted capitation formula

Therefore, 2011-12 weighted populations have been used when calculated the Running Costs per head of population in 2012-13

5.2 Analysis of operating expenditure by expenditure classification

	2012-13	2011-12
	£000	£000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	28,544	28,536
Prescribing costs	30,267	31,256
Contractor led GDS & PDS	9,929	9,992
Trust led GDS & PDS	750	744
General Ophthalmic Services	1,915	1,873
New Pharmacy Contract	7,282	7,255
Non-GMS Services from GPs	3,270	3,057
Total Primary Healthcare purchased	**81,957**	82,713
Purchase of Secondary Healthcare		
Learning Difficulties	2,667	1,561
Mental Illness	28,033	30,125
Maternity	10,666	12,160
General and Acute	189,038	169,794
Accident and emergency	7,982	13,657
Community Health Services	45,868	40,443
Other Contractual	1,165	2,043
Total Secondary Healthcare Purchased	**285,419**	269,783
Grant Funding		
Grants for capital purposes	484	0
Grants for revenue purposes	0	0
Total Healthcare Purchased by PCT	**367,860**	**352,496**
Healthcare from NHS FTs included above	95,066	95,660

6. Operating Leases

6.1 PCT as lessee

	Land	Buildings	Other	2012-13 Total	2011-12
	£000	£000	£000	£000	£000
Payments recognised as an expense					
Minimum lease payments				18	14
Contingent rents				0	0
Sub-lease payments				0	0
Total				18	14
Payable:					
No later than one year	0	0	14	14	14
Between one and five years	0	0	14	14	28
After five years	0	0	0	0	0
Total	0	0	28	28	42
Total future sublease payments expected to be received				0	0

6.2 PCT as lessor

	2012-13	2011-12
	£000	£000
Recognised as income		
Rental Revenue	536	533
Total	536	533
Receivable:		
No later than one year	536	533
Between one and five years	1,608	2,132
Total	2,144	2,665

7. Employee benefits and staff numbers

7.1 Employee benefits

	2012-13			Permanently employed		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits - Gross Expenditure						
Salaries and wages	4,788	2,329	2,459	3,388	1,456	1,932
Social security costs	337	229	108	337	229	108
Employer Contributions to NHS BSA - Pensions Division	462	319	143	462	319	143
Termination benefits	226	92	134	226	92	134
Total employee benefits	5,813	2,969	2,844	4,413	2,096	2,317
Less recoveries in respect of employee benefits (table below)	0	0	0	0	0	0
Total - Net Employee Benefits including capitalised costs	5,813	2,969	2,844	4,413	2,096	2,317
Employee costs capitalised	0	0	0	0	0	0
Gross Employee Benefits excluding capitalised costs	5,813	2,969	2,844	4,413	2,096	2,317
Recognised as:						
Commissioning employee benefits	5,813			4,413		
Provider employee benefits	0			0		
Gross Employee Benefits excluding capitalised costs	5,813			4,413		

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	3,549	3,332	217
Social security costs	321	321	0
Employer Contributions to NHS BSA - Pensions Division	497	497	0
Termination benefits	21	21	0
Total gross employee benefits	4,388	4,171	217
Less recoveries in respect of employee benefits	0	0	0
Total - Net Employee Benefits including capitalised costs	4,388	4,171	217
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised costs	4,388	4,171	217
Recognised as:			
Commissioning employee benefits	4,388		
Provider employee benefits	0		
Gross Employee Benefits excluding capitalised costs	4,388		

7.2 Staff Numbers

	2012-13			2011-12		
	Total Number	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number
Average Staff Numbers						
Medical and dental	3	3	0	4	4	0
Administration and estates	82	63	19	66	65	1
Nursing, midwifery and health visiting staff	4	4	0	6	6	0
Scientific, therapeutic and technical staff	3	3	0	3	3	0
Other	1	1	0	10	10	0
TOTAL	94	75	19	89	87	1
Of the above - staff engaged on capital projects	0	0	0	0	0	0

7.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	467	433
Total Staff Years	77	95
Average working Days Lost	6.05	4.56

7.4 Exit Packages agreed during 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
Lees than £10,000	2	0	2	0	0	0
£10,001-£25,000	3	0	3	0	0	0
£25,001-£50,000	4	0	4	0	0	0
Total number of exit packages by type (total cost	9	0	9	0	0	0
	£	£	£	£	£	£
Total resource cost	225,730	0	225,730	0	0	0

This note provides an analysis of Exit Packages agreed during the year. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Where the PCT has agreed early retirements, the additional costs are met by the PCT and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages taken by staff leaving in the year. Note: The expense associated with these departure: may have been recognised in part or in full in a previous period.

7.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervenir years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2013, is based on the valuation data as 31 March 2012, updated to 31 March 2013 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

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Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the statement of comprehensive income at the time the PCT commits itself to the retirement, regardless of the method of payment.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**7,509**	**37,927**	13,452	34,699
Total Non-NHS Trade Invoices Paid Within Target	**6,385**	**34,215**	12,065	29,809
Percentage of NHS Trade Invoices Paid Within Target	85.03%	90.21%	89.69%	85.91%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,663**	**294,266**	3,132	259,217
Total NHS Trade Invoices Paid Within Target	**3,147**	**290,788**	2,736	249,070
Percentage of NHS Trade Invoices Paid Within Target	85.91%	98.82%	87.36%	96.09%

The Better Payment Practice Code requires the Care Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

9. Investment Income

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest Income				
LIFT: equity dividends receivable	0	0	0	20
LIFT: loan interest receivable	177	177	0	39
Subtotal	177	177	0	59
Total investment income	177	177	0	59

10. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest				
Interest on obligations under LIFT contracts:				
- main finance cost	259	0	259	402
Total interest expense	259	0	259	402
Provisions - unwinding of discount	1		1	9
Total	260	0	260	411

11.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2012	**5,724**	**10,910**	**0**	**83**	**707**	**59**	**2,567**	**727**	**20,776**
Additions of Assets Under Construction				581					**581**
Additions Purchased	0	0	0		0	0	595	0	**595**
Reclassifications	0	664	0	(664)	0	0	0	0	**0**
Upward revaluation/positive indexation	80	26	0	0	0	0	0	0	**106**
Impairments/negative indexation	(22)	(1,380)	0	0	0	0	0	0	**(1,402)**
At 31 March 2013	**5,782**	**10,220**	**0**	**(0)**	**707**	**59**	**3,162**	**727**	**20,656**
Depreciation									
At 1 April 2012	**0**	**600**	**0**	**0**	**410**	**29**	**1,589**	**430**	**3,059**
Upward revaluation/positive indexation	0	(326)	0		0	0	0	0	**(326)**
Charged During the Year	0	325	0		86	8	285	74	**778**
At 31 March 2013	**0**	**599**	**0**	**0**	**496**	**37**	**1,874**	**504**	**3,511**
Net Book Value at 31 March 2013	**5,782**	**9,621**	**0**	**(0)**	**211**	**22**	**1,287**	**223**	**17,145**
Purchased	5,782	9,621	0	(0)	211	22	1,287	223	**17,145**
Total at 31 March 2013	**5,782**	**9,621**	**0**	**(0)**	**211**	**22**	**1,287**	**223**	**17,145**
Asset financing:									
Owned	4,662	5,547	0	(0)	211	22	1,287	223	**11,951**
On-SOFP PFI contracts	1,120	4,074	0	0	0	0	0	0	**5,194**
Total at 31 March 2013	**5,782**	**9,621**	**0**	**(0)**	**211**	**22**	**1,287**	**223**	**17,145**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	**3,814**	**1,428**	**0**	**0**	**52**	**0**	**14**	**0**	**5,308**
Movements (specify)	58	(1,028)	0	0	0	0	0	0	**(970)**
At 31 March 2013	**3,872**	**400**	**0**	**0**	**52**	**0**	**14**	**0**	**4,338**

11.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation:									
At 1 April 2011	**4,212**	**11,550**	**0**	**431**	**707**	**59**	**2,149**	**727**	**19,834**
Additions - purchased	0	0	0	84	0	0	0	0	**84**
Reclassifications	0	14	0	(432)	0	0	418	0	**0**
Revaluation & indexation gains	1,555	91	0	0	0	0	0	0	**1,646**
Impairments	(43)	(745)	0	0	0	0	0	0	**(787)**
At 31 March 2012	**5,724**	**10,910**	**0**	**83**	**707**	**59**	**2,567**	**727**	**20,777**
Depreciation									
At 1 April 2011	**0**	**0**	**0**		**319**	**21**	**1,255**	**353**	**1,947**
Impairments	0	94	0	0	0	0	0	0	**94**
Charged During the Year	0	506	0		91	8	334	79	**1,019**
At 31 March 2012	**0**	**600**	**0**	**0**	**410**	**29**	**1,590**	**432**	**3,060**
Net Book Value at 31 March 2012	**5,724**	**10,310**	**0**	**83**	**297**	**30**	**976**	**295**	**17,717**
Purchased	5,724	10,310	0	83	297	30	977	297	**17,717**
At 31 March 2012	**5,724**	**10,310**	**0**	**83**	**297**	**30**	**977**	**297**	**17,717**
Asset financing:									
Owned	4,604	5,910	0	83	297	30	977	297	**12,197**
On-SOFP PFI contracts	1,120	4,400	0	0	0	0	0	0	**5,520**
At 31 March 2012	**5,724**	**10,310**	**0**	**83**	**297**	**30**	**977**	**297**	**17,717**

11.3 Property, plant and equipment

Land and Property assets were revalued by the District Valuer as a valuation exercise at 31st March 2013 prices.

The valuations have been undertaken having regard to International Financial Reporting Standards (IFRS) as applied to the United Kingdom public sector and in accordance with HM Treasury guidance, International Valuation Standards and the requirements of the Royal Institution of Chartered Surveyors (RICS) Valuation Standards 6th Edition.

The valuations were carried out by Peter Ashby MRICS, RICS Registered Valuers of DVS

Public sector bodies including the NHS are required to apply the Revaluation model set out in IAS 16 and value their capital assets to fair value.

Fair value is defined in IAS16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. The fair value of land and buildings is usually determined from market-based evidence by appraisal undertaken by professionally qualified valuers.

The valuation of each property is therefore on the basis of Market Value, subject to the following:

The RICS advises that *assumptions* underpinning the concepts of *fair value should be explicitly stated* and identifies two potential

- "The Market Value on the assumption that the property is sold as part of the continuing enterprise in occupation" (effectively EUV);
- "The Market Value on the assumption that the property is sold following a cessation of the existing operations" (in effect the

The Department of Health has indicated that for NHS assets it requires the former assumption to be applied for operational assets and the District Valuer has confirmed that approach was followed in his report.

Disposals
The Care Trust did not dispose of any non current assets materially below the valuation by professional valuers.

The valuations were carried out Peter Ashby MRICS,
RICS of DVS

11.4 Economic Lives of Non-Current Assets

	2012-13		201
	Min Life Years	Max Life Years	Min Life Years
Property, Plant and Equipment			
Buildings excl. Dwellings	6	48	7
Plant & Machinery	2	15	3
Transport Equipment	5	6	6
Information Technology	1	5	2
Furniture and Fittings	2	9	3

12. Analysis of impairments and reversals recognised in 2012-13

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Total Impairments charged to Revaluation Reserve	1,402	741	661
Overall Total Impairments	**1,402**	**741**	**661**

13 Commitments

13.1 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2013	31 March 2012
	£000	£000
Property, plant and equipment	0	0
Intangible assets	0	0
Total	**0**	0

The Care Trust has no contracted capital commitments at 31 March not otherwise included in these financial statements:

14 Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with other Central Government Bodies	935	0	999	0
Balances with NHS Trusts and Foundation Trusts	317	0	7,237	0
Balances with bodies external to government	1,720	152	15,677	0
At 31 March 2013	**2,972**	**152**	**23,913**	**0**
prior period:				
Balances with other Central Government Bodies	1,260	0	1,001	0
Balances with Local Authorities	105	0	0	0
Balances with NHS Trusts and Foundation Trusts	3,589	0	4,159	0
Balances with bodies external to government	1,064	151	17,022	0
At 31 March 2012	**6,018**	**151**	**22,182**	**0**

15.1 Trade and other receivables

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
NHS receivables - revenue	**465**	3,568	**0**	0
NHS receivables - capital	**44**	0	**0**	0
NHS prepayments and accrued income	**743**	1,132	**0**	0
Non-NHS receivables - revenue	**230**	460	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**1,074**	848	**152**	151
Provision for the impairment of receivables	**(59)**	(152)	**0**	0
VAT	**474**	149	**0**	0
Other receivables	**1**	13	**0**	0
Total	**2,972**	6,018	**152**	151
Total current and non current	**3,124**	6,169		
Included above:				
Prepaid pensions contributions	**0**	0		

The majority of trade is with other NHS bodies, including other Primary Care Trusts as commissioners for NHS patient care services. As Primary Care Trusts are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

15.2 Receivables past their due date but not impaired

	31 March 2013	31 March 2012
	£000	£000
By up to three months	**4**	508
By three to six months	**0**	135
By more than six months	**125**	12
Total	**129**	655

15.3 Provision for impairment of receivables

	2012-13	**2011-12**
	£000	**£000**
Balance at 1 April 2012	**(152)**	(147)
Amount written off during the year	**3**	0
Amount recovered during the year	**0**	104
(Increase)/decrease in receivables impaired	**90**	(109)
Balance at 31 March 2013	**(59)**	(152)

In order to arrive at the bad debt provision, the Care Trust reviewed the aged debt analysis and assessed all the items over 90 days old or where queries had been raised and made an informed judgement as to the likelihood of recovery.

16 NHS LIFT investments

	Loan £000	Share capital £000	Total £000
Balance at 1 April 2012	**158**	**0**	**158**
Balance at 31 March 2013	**158**	**0**	**158**
Revaluations	158	0	158
Balance at 31 March 2012	**158**	**0**	**158**

17.1 Other Financial Assets - Non Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April	**158**	0
Additions	131	0
Total Other Financial Assets - Non Current	**289**	0

17.2 Other Financial Assets - Capital Analysis

	31 March 2013 £000	31 March 2012 £000
Capital Expenditure	**131**	0

18 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**1**	34
Net change in year	**301**	(33)
Closing balance	**302**	1
Made up of		
Cash with Government Banking Service	**302**	1
Cash and cash equivalents as in statement of financial position	**302**	1
Cash and cash equivalents as in statement of cash flows	**302**	1
Patients' money held by the PCT, not included above	**0**	0

19 Trade and other payables

	Current		Non-current	
	31 March 2013	31 March 2012	31 March 2013	31 March 2012
	£000	£000	£000	£000
Interest payable	0	0		
NHS payables - revenue	8,236	5,160	0	0
Family Health Services (FHS) payables	9,437	5,038		
Non-NHS payables - revenue	3,485	8,916	0	0
Non_NHS accruals and deferred income	2,371	3,062	0	0
Social security costs	2	0		
VAT	3	0	0	0
Tax	10	1		
Payments received on account	0	3	0	0
Other	369	1	0	0
Total	23,913	22,182	0	0
Total payables (current and non-current)	23,913	22,182		

20 Borrowings

	Current		Non-current	
	31 March 2013	31 March 2012	31 March 2013	31 March 2012
	£000	£000	£000	£000
LIFT liabilities:				
Main liability	163	134	4,309	4,473
Finance lease liabilities	0	0	0	0
Total	163	134	4,309	4,473
Total other liabilities (current and non-current)	4,472	4,607		

Borrowings/Loans - Payment of Principal Falling Due in:

	DH	Other	Total
	£000s	£000s	£000s
0 - 1 Years	0	163	163
1 - 2 Years	0	129	129
2 - 5 Years	0	388	388
Over 5 Years	0	3,792	3,792
TOTAL	0	4,472	4,472

21 Provisions

Comprising:

	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Restructuring £000s	Continuing Care £000s	Equal Pay £000s	Agenda for Change £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	**483**	0	12	21	0	115	0	0	335	0
Arising During the Year	**7,191**	0	0	0	0	7,191	0	0	0	0
Utilised During the Year	**(350)**	0	(6)	(9)	0	0	0	0	(335)	0
Reversed Unused	**(8)**	0	(6)	(2)	0	0	0	0	0	0
Unwinding of Discount	**1**	0	1	0	0	0	0	0	0	0
Balance at 31 March 2013	**7,317**	**0**	**1**	**10**	**0**	**7,306**	**0**	**0**	**0**	**0**
Expected Timing of Cash Flows:										
No Later than One Year	**4,685**	**0**	**1**	**10**	**0**	**4,674**	**0**	**0**	**0**	**0**
Later than One Year and not later than Five Years	**2,632**	**0**	**0**	**0**	**0**	**2,632**	**0**	**0**	**0**	**0**

Continuing Care Provisions

In March 2012 the Department of Health announced deadlines for individuals or their representatives to notify the relevant PCT if they believe there was a period of care between 1st April 2004 and 31st March 2012 where there is evidence that the individual should have been assessed for eligibility for NHS continuing healthcare (NHS CHC). This only applies to new cases i.e. where, the individual has not previously been assessed for NHS CHC during the identified period. The first deadline was the 30th September 2012 relating to claims between 1st April 2004 to 31st March 2011. The second deadline was 31st March 2013 relating to the period from 1st April 2011 to 31st March 2012. The PCT received a total of 288 claims representing a significant financial risk to the organisation. The process of assessing the impact of these claims has been ongoing through the year and a financial provision has been made based on estimates of the potential financial exposure using the latest information available at the time.

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	**£000s**
As at 31 March 2013	17
As at 31 March 2012	74

"Other" provisions comprises the balance of Back to Back
Back to Back provisions are held with other Trusts and Foundation Trusts for pensions and legal claims. The timing is based on an estimation received from the relevant Trust.

22 Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Other	(9,629)	(425)
Net Value of Contingent Liabilities	(9,629)	(425)

The contingent liability relates to 288 Continuing Care cases (7 in 2011-12).

23 LIFT - additional information

The Care Trust entered into a 'Local Improvement Finance Trust' procurement arrangement in 2005 for premises developments and improvements with Bromley and Greenwich PCTs. Lakeside in Thamesmead was fully operational from November 2007. Services delivered from the Lakeside include General Practice, Community, Urgent Care Centre, Diagnostics and Outpatients. The current lease plus arrangement is for a period of 25 years which expires on 30th June 2031.
The current gross rental payment is £676,000 per annum. The Care Trust has the option to purchase the asset at the end of the lease.
Under IFRIC 12 the investment is treated as a LIFT asset of the PCT, the substance of the contract is that the PCT has a finance LIFT arrangement and payments comprise the two elements of imputed finance lease charges and service charges.

	31 March 2013	31 March 2012
	£000	£000
23.1 Charges to operating expenditure and future commitments in respect of ON and OFF SOFP LIFT		

Charges to operating expenditure and future commitments in respect of on and off SOFP LIFT	**31 March 2013**	31 March 2012
	£000	£000
Total Charge to Operating Expenses in year - OFF SOFP LIFT	**0**	0
Service element of on SOFP LIFT charged to operating expenses in year	**63**	63
Total	**63**	63

	31 March 2013	31 March 2012
	£000	£000
Payments committed to in respect of off SOFP LIFT and the service element of on SOFP LIFT.		
LIFT Scheme Expiry Date:		
No Later than One Year	**63**	82
Later than One Year, No Later than Five Years	**521**	405
Later than Five Years	**1,977**	2,155
Total	**2,561**	2,642

Imputed "finance lease" obligations for on SOFP LIFT Contracts due	**31 March 2013**	31 March 2012
	£000	£000
No Later than One Year	**542**	524
Later than One Year, No Later than Five Years	**1,899**	2,015
Later than Five Years	**6,947**	7,374
Subtotal	**9,388**	9,913
Less: Interest Element	**(4,916)**	(5,306)
Total	**4,472**	4,607

24 Impact of IFRS treatment - 2012-13

	Total	Admin	Programme
	£000	£000	£000
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g LIFT/PFI)			
Depreciation charges	**0**	0	0
Interest Expense	**0**	0	0
Impairment charge - AME	**0**		0
Impairment charge - DEL	**0**	0	0
Other Expenditure	**0**	0	0
Revenue Receivable from subleasing	**0**	0	0
Total IFRS Expenditure (IFRIC12)	**0**	**0**	**0**
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	**0**	0	0
Net IFRS change (IFRIC12)	**0**	**0**	**0**

Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12	
Capital expenditure 2012-13	0
UK GAAP capital expenditure 2012-13 (Reversionary Interest)	0

25 Financial Instruments

Financial risk management
Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. As the cash requirements of the Care Trust are met through Parliamentary Funding, financial instruments play a more limited role in creating risk that would apply to a non-public sector body of a similar size. The majority of financial instruments relate to contracts for non-financial items in line with the Care Trust's expected purchase and usage requirements and the Care Trust is therefore exposed to little credit, liquidity or market list.

Currency risk

The Care Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Care Trust has no overseas operations. The Care Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
Care Trusts are not permitted to borrow. The Care Trust therefore has low exposure to interest-rate fluctuations

Credit Risk
Because the majority of the Care Trust's income comes from funds voted by Parliament the Care Trust has low exposure to credit risk.

Liquidity Risk
The Care Trust is required to operate within limits set by the Secretary of State for the financial year and draws down funds from the Department of Health as the requirement arises. The Care Trust is not, therefore, exposed to significant liquidity risks.

25.1 Financial Assets	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000	£000	£000	£000
Receivables - NHS		1,252		1,252
Receivables - non-NHS		172		172
Cash at bank and in hand		302		302
Other financial assets	289	152	0	441
Total at 31 March 2013	**289**	**1,878**	**0**	**2,167**
Receivables - NHS		3,568		3,568
Receivables - non-NHS		308		308
Cash at bank and in hand		1		1
Other financial assets	158	13	0	171
Total at 31 March 2012	158	3,890	0	4,048

25.2 Financial Liabilities	At 'fair value through profit and loss'	Other	Total
	£000	£000	£000
Embedded derivatives	0		0
NHS payables		8,237	8,237
Non-NHS payables		15,652	15,652
PFI & finance lease obligations		4,472	4,472
Total at 31 March 2013	**0**	**28,361**	**28,361**
Embedded derivatives	0		0
NHS payables		5,160	5,160
Non-NHS payables		13,954	13,954
PFI & finance lease obligations		4,607	4,607
Other financial liabilities	0	3,002	3,002
Total at 31 March 2012	0	26,723	26,723

There are no differences in the fair value of financial assets or financial liabilities from the carrying book amounts:

26 Related party transactions

Bexley Primary Care Trust is a body corporate established by order of the Secretary of State for Health.

Based upon declarations of interest made by Executive, Non Executive and Borough Clinical Commissioning Collaborative Committee members, related parties were identified and the value of transactions are included below.

Details of related party transactions with individuals during 2012/13 are as follows:

	Services Received from Organisation	Payments to Related Party
		£'s
Dr V Bhalla - Belvedere Medical Practice	Primary Care	815,940
Dr W Cotter - Bellegrove Surgery	Primary Care	1,584,716
Dr W Cotter - Clocktower Healthcare Ltd	Primary Care	559,462
Dr W Cotter - Bellegrove Medical Services Ltd	Primary Care	16,215
Dr S Deshmukh - Sidcup Medical Centre	Primary Care	853,115
Dr S Chase - Woodlands Primary Care	Primary Care	1,291,542
Dr S Bhadra - Goodhealth PMS	Primary Care	758,514

The Department of Health is regarded as a related party. During the year Bexley Care Trust had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent Department.

		£000's
Dartford and Gravesham NHS Trust	Provision of Healthcare	26,225
South London Healthcare Trust	Provision of Healthcare	95,506
Guys And St Thomas NHS Foundation Trust	Provision of Healthcare	29,817
Oxleas NHS Foundation Trust	Provision of Healthcare	43,609
London Borough of Bexley	Healthcare from non-NHS Bodies	7,846

2011-12 (Restated)

		£'s
Keith Wood-Greenwich & Bexley Community Hospice Ltd	Non Acute	1,382,381
Dr William Cotter - Bellgrove Surgery	Primary Care	1,399,328
Dr Sid Deshmukh- Sidcup Medical Centre & Bexley Health Ltd	Primary Care	1,123,767
Dr Varun Bhalla- Belvedere Medical Centre	Primary Care	822,726

		£000's
Dartford and Gravesham NHS Trust	Provision of Healthcare	25,461
South London Healthcare Trust	Provision of Healthcare	87,172
Guys And St Thomas NHS Foundation Trust	Provision of Healthcare	29,105
Oxleas NHS Foundation Trust	Provision of Healthcare	43,799
Camden and Islington NHS Foundation Trust	Provision of Healthcare	18,774
London Borough of Bexley	Healthcare from non-NHS Bodies	4,376

27 Losses and special payments

The total number of losses cases in 2012-13 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses - PCT management costs	2,509	11
Special payments - PCT management costs	0	0
Losses in respect of the provision of family practitioner services	0	0
		0
Special payments in respect of he provision of family practitioner services	0	
Total losses	2,509	11
Total special payments	0	0
Total losses and special payments	2,509	11

There were no losses or special payments in 2011-12.

28 Events after the end of the reporting period

As disclosed within note 1.1 due to the Health and Social Care Bill as of 1st April 2013 the PCT in its current legal form will be abolished. As a result the PCT's functions will continue with either a Commissioning Support Unit (CSU), Clinical Commissioning Group (CCG), NHS England, NHS Foundation Trusts (FT) or Local Authorities (LA). Estates functions will be transferred to NHS Property Services Limited (NHS PS). Ultimate control will still reside with the Department of Health.

All assets and liabilites contained within the statement of financial position as at 31st March 2013 must be identified and agreed for transfer.

Under this NHS Transition, the PCT's assets and liabilities will be split between different 'Receivers' and, in some cases, multiple 'Receivers' will require access to an asset or be assigned a liability. The principles for the split of residual balances is still subject to Department of Health guidance.

The majority of assets and liabilities (including all land and buildings) will transfer by way of a 'Sender' organisation's Transfer Schemes. A Transfer Scheme is an instrument in writing made by the Secretary of State under sections 300 to 302 of the Act. It can deal with the transfers of staff, property and liabilities between those entities as specified in Schedules 22 and 23 to the Act but unlike Transfer Orders does not need to be laid before Parliament.

Where functions transfer, any claim, liability and financial asset, which relate to that will follow. However NHS England will take historical NHS Litigation Authority (NHSLA) indemnified clinical negligence claims, including those incurred but not reported relating to new functions of CCG's or Local Authorities.

28 Events after the end of the reporting period (Cont'd)

The final year-end aggregate surplus generated by the PCTs in 2012/13 will be carried forw
NHS England in 2013/14. CCGs will not inherit legacy debt, but balances will transfer from I
line with provisions of the Act, based on the principles set out below, subject to further guida
the Department of health on the split of financial balances and related financial transactions

- Liabilities that correspond to an asset which relate to a particular function should transfer
asset from a sender to a receiver by reference to the destination of the function.

- Liabilities that correspond to a function or policy that is being moved from a sender should
the nominated receiver for that function.

- Discrete, and current assets and liabilities, even if associated with a function continuing in
will transfer to the Department of Health.

- Liabilities relating to the PCT as a statutory body in its own right that do not relate to an o
function such as VAT or tax liabilities, will transfer to the Department of Health.

- Employer liabilities will transfer to the new employer, where an individual's employment is
transferred to a receiver organisation.

- Where employment of staff ceases prior to 1st April 2013, the employer liabilities related t
staff members will transfer to Department of Health.

Bexley Care Trust (BCT)

Organisation Code: TAK

1. Scope of responsibility

As signing officer delegated by the Department of Health's Accounting Officer I have taken assurances from the Accountable Officer for 2012-13 that he took responsibility for maintaining a sound system of internal control that supports the achievement of Bexley Care Trust (BCT) policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am responsible. I am also responsible for ensuring that BCT is administered prudently and economically and that resources are applied efficiently and effectively. These responsibilities are as set out in the Accountable Officer Memorandum.

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of BCT, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in BCT for the year ended 31 March 2013.

In the reporting year ending 31 March 2013, the Primary Care Trusts and Care Trusts ceased to exist. Bexley Clinical Commissioning Group (BCCG) started its operation in shadow form from 1st October 2012 with an aim to be authorised by 1st April 2013.

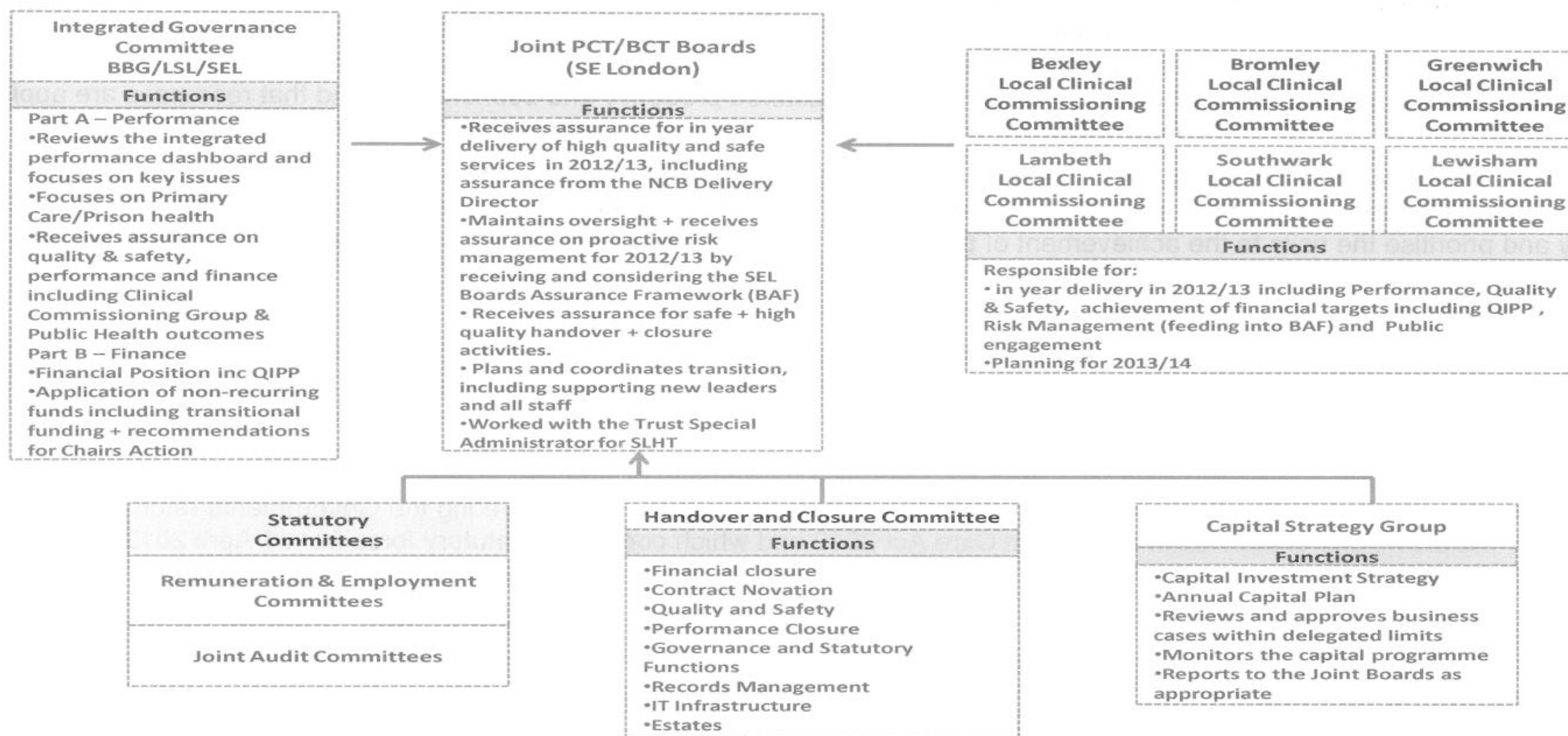
NHS South East London was established on 1 April 2011 and is a partnership of Bromley, Greenwich, Lambeth, Lewisham and Southwark Care Trusts and Bexley Care Trust. This change was a first step towards delivering the Governments reforms to the NHS under the provisions of the Health and Social Care Act 2012 and which come into statutory force from 1 April 2013. In this document NHS South East London is sometimes referred to as a "PCT Cluster" or "Cluster".

NHS South East London covers a population of 1,568,000. There are four acute hospital trusts, two of which are Foundation Trusts, two mental health Foundation Trusts, and a diverse and active community sector. An Academic Health Sciences Centre consisting of Guy's and St Thomas', King's, South London and Maudsley and King's College London has also been formed. There are 271 GP practices and six community care providers, five of which have integrated with local NHS providers with one becoming a social

enterprise.

2. The governance framework of the organisation

The Governance Framework is comprised of the Boards and Boards Committees detailed in the following diagram:



Joint South East London PCT/Care Trust Boards

- The Joint Boards are six individual PCT/Care Trust Boards that work together as one entity, undertaking the duties that are enshrined in law relating to the governance of Primary Care Trusts and Care Trusts. Certain mandatory positions on the Boards, such as the Chair and Chief Executive, are fulfilled by the same individual across all of the Boards, while other positions are taken by local Primary Care Trust (PCT) and Care Trust's Managing Directors and locally-focused non-executive directors. The Boards focus on developing strategies and priorities for the entirety of NHS South East London (NHS SEL) including Bexley Care Trust, ensuring that the clinical commissioning committees are fulfilling their duties, in accordance with what is delegated to them.

- During 2012/13 the Joint Boards:
  - Implemented the revised Governance arrangements agreed on 26 January 2012 reflecting the new shadow Clinical Commissioning Group (CCG) arrangements in place from 1 October 2012
  - Agreed revised arrangements for managing conflicts of interest in NHS SEL
  - Adopted revised Corporate Governance Arrangements enacting the Transition
  - Reviewed and updated the Boards Assurance Framework at every Boards meeting.
  - Considered risk at every meeting and received assurance via an exception reporting arrangement, the format for which was considerably strengthened by the Boards during the year. This approach was supported through the delegation process whereby each borough Local Clinical Commissioning Committee (LCCC) reviewed risks relevant to their populations. The Joint Audit Committees (JAC) tested the system and process of assurance.
  - At each meeting received and considered reports on the following topics:
    - Quality and Performance
    - Finance
    - Integrated Governance
    - Local Clinical Commissioning Committees
    - Transition and Handover & Closure including:
      - Clinical Commissioning Groups
      - The South London Commissioning Support Unit
    - Individual matters reserved to the Joint Boards

- The Joint Boards' Assurance Framework is publically available on the NHS SEL website.
- In 2012/13 the Boards met every two months, in public. All meetings were quorate for all Boards.

The Boards have assessed their own performance and effectiveness, including their compliance with key elements of the Code of Conduct and Code of Accountability for NHS Boards. Views were obtained via an anonymous online survey designed in keeping with the structure and format of a comparable survey last year. Twenty two returns were received from the Joint Boards membership of thirty four.

In the key areas of governance, there was a 100% satisfaction rating that governance arrangements enable members to identify and, when necessary, declare potential conflicts of interest when conducting Board business. There was also a near unanimous satisfaction rating in the following areas (with one member disagreeing):

- the Joints Boards' ability to support the fulfillment of the statutory duties of the constituent PCTs and Care Trust
- ensuring effective financial control, financial planning and value for money.

Overall, members were also satisfied that:

- the Cluster's governance arrangements support the achievement of the standards and targets set out in the NHS Operating Framework;
- that there is clarity on the role of the Joint Boards and on responsibilities that can be delegated to committees and officers; and
- that the Joint Boards and their committees provide clarity on who is to take action following decisions made.

A small number of members did not agree that the Joint Boards have the opportunity to explore all the challenges and opportunities faced by the Cluster, although this was tempered by comment that such a situation was not, perhaps, surprising, given the considerable focus having to be devoted to the transition.

More members (though still a minority) recorded concerns about the amount of information sent to them for meetings, together with the limited time given to digest it. Though fewer members felt that duplication in the business and decision-making between the Joint Boards and their committees had taken place, perhaps, demonstrating the success of our arrangements for delegation and the implementation of revised governance arrangements during spring 2012.

Notwithstanding the reflections detailed above, the Chair and Chief Executive believe that there has been no material departure from the Code of Conduct and Code of Accountability for NHS Boards and none has been suggested by other Board members

Bexley Local Clinical Commissioning Committee (LCCC)

- Bexley (LCCC) was a committee of the Bexley Care Trust Board. Its role over 2012/13 had been to take on delegated responsibility for the commissioning for those areas to be incorporated within clinical commissioning for Bexley. The LCCC was a pathfinder Clinical Commissioning Group (CCG) and over the course of the year took full delegation of non-acute commissioning responsibilities. The LCCC addressed full authorisation of Bexley CCG as a statutory organisation in 2012/13. The development of Bexley CCG was expected to replace the Care Trust as commissioners of local health services from April 2013 in line with the new legislation. This clinically-led LCCC aimed to engage with all 28 Bexley practices covering three Bexley localities and was supported by NHS Bexley Business Support Unit and NHS South East London-wide shared teams to identify local healthcare needs and commission services for the population of Bexley based on agreed strategic priorities. Over the past year the LCCC also undertook the duties of the Professional Executive Committee (PEC). The CCG development was scheduled with the DoH's implementation wave 4 for establishing CCGs and was expected to start its operations as Clinical Commissioning Group on 1st April 2013. BCCG had been operating in the shadow form since October 2012 until full authorisation providing a continued service and responsibility of commissioning of services for its population. NHS Bexley Clinical Commissioning Group have been given the green light by the NHS Commissioning Board to commission the majority of healthcare services for the borough's population of 232,000 from April 1. Bexley CCG. The CCG, will plan, monitor and buy health services for local people in the borough. This means the CCG, made up of local GP practices, will decide how to spend a budget of £263million on local healthcare.

- Following the authorisation inspection by the NHS Commissioning Board, NHS Bexley Clinical Commissioning Group (BCCG) successfully met 116 of the 119 assessment indicators. The panel was impressed with the CCGs clear and creative plans, partnership working, especially with the London Borough of Bexley, patient and public involvement, clinical leadership models and the two-way communication between the CCG and governing body.

- In 2012/13 Bexley Care Trust developed its commissioning intentions to improve quality and performance. Key stakeholders, including patients, patient interest groups, clinicians, providers, voluntary groups/organisations and the local authority, were able to feed into this process by attending events or submitting their feedback directly to the care trust. This engagement was also used to develop the commissioning intentions for the emerging Clinical Commissioning Group. More than 240 people attended the two engagement events in October 2012, providing specialist advice and input, to help the CCG strengthen its plans.

- The BCCC provided a summary report to every Joint Board meeting including reporting on its delegated responsibilities. During 2012/13 the formal BLCCC held eight meetings in public and all were quorate. A full copy of the minutes is available by contacting the relevant successor organisation (Legacy Management Organisation South East London).

Joint Audit Committees

- The Joint Audit Committees (JAC) fulfil the statutory audit functions required of PCTs and Care Trusts, ensuring that the governance and machinery of the cluster and the PCTs/Care Trust is functioning as it should. Their work programme includes reviewing governance arrangements (including Information Governance), assurance mechanisms including the work of internal and external audit, local counter fraud and security management services, debt and waiver management, and reviewing the Board Assurance Framework to make sure that corporate objectives and organisational risks are properly addressed.
- During 2012/13 the JAC considered all residual risks and Assurance Frameworks from the PCTs / Care Trust in SEL. The Committee reviewed the Assurance Framework at every meeting.
- The JAC considered each of the six individual PCTs/Care Trust Annual Accounts, Audit opinions, Annual Reports and Annual Governance Statements for 2011/12 at its meetings on the 9 and 30 May 2012. .
- On 9 January 2013 the JAC received and considered the Annual Audit Letters
- On 13 and 27 March 2013 the JAC considered each of the six individual PCTs/ Care Trust draft Annual Reports and Annual Governance Statements, along with the interim work on the 2012/13 Annual Accounts undertaken by internal and external audit. Year end documents will be finalised and approved post 31 March 2013 through the temporary mechanism being designed by the Department of Health.
- The JAC has increased its engagement with PCT/Care Trust Chief Finance Officers and Chief Officers; both are now routinely invited to meetings.
- The JAC meet at least quarterly. Meetings are not held in public but activities are reported to the Joint Boards. All meetings in 2012/13 were quorate.

Integrated Governance Committee (IGC)

The IGC has the following roles and responsibilities:-

- To oversee the integrated governance of the shadow CCGs and give the Joint Boards assurance that actions and plans put in place by the CCGs are appropriate, adequate and followed through as they work towards Authorisation.
- To give a forum for the shadow CCGs to operate at scale to manage the performance and quality of the major acute, community and mental health providers
- To help enable the Cluster Chief Executive to exercise his role as Accountable Officer through consideration and review of the aggregate Cluster position with respect to performance, finance, quality and emergency planning
- To review and consider the quality and performance of Care, Prison Health and Specialist Services prior to full

establishment of the National Commissioning Board

- To oversee the procedures for identifying, investigating and learning for serious incidents and for safeguarding children and vulnerable adults.
- The Committee meets monthly and all meetings were quorate during 2012/13
- Meetings are not held in public but a summary report detailing issues discussed and actions proposed is provided at each Joint Boards meeting.

Handover and Closure Committee

- Oversaw all aspects of the Handover and Closure programme in the NHS in South East London.
- The Committee meets in private but provides its minutes to the Joint Boards. All meetings in 2012/13 were quorate.

Capital Strategy Group

- Oversaw all aspects of Capital Strategy, planning and progress in the NHS in South East London
- The Group meets in private but considers issues prior to their decision at public meetings of LCCCs or the Joint Boards. All meetings in 2012/13 were quorate.

Joint Remuneration and Employment Committee

- The Joint Remuneration and Employment Committee meets to consider the employment packages for those employees of the cluster whose remuneration fall outside the scope of Agenda for Change.
- The Committee meets as required and in private. All meetings in 2012/13 were quorate.

Assurance

In July 2012 Internal Audit carried out a review of CCG Governance and Delegation. While the audit was forward looking it also encompassed aspects of current practice. The audit concluded that for Bexley Care Trust the design and operation of governance arrangements for the CCG authorisation process and shadow year were **adequate** (Green RAG rating). A summary of recommendations is given below:

Organisation	Assurance Level	Recommendations by Priority		
		High	Medium	Low*
Bexley (Made/accepted)	Adequate	0	0	3/3
Summary of Audit	**Adequate**	**0**	**0**	**3/3**

*Low Priority	Recommendations which could improve the efficiency and/or effectiveness of the system or process but which are not vital to achieving strategic aims and objectives. These are generally issues of good practice that the auditors consider would achieve better outcomes.

3. Risk Assessment

3.1. Introduction

The BCT's approach to risk management and board assurance is in accordance with legislation, national and local guidance. It seeks to embed recognised and developed best practice through a process of ongoing review and improvement and underpins the production of the Annual Governance Statement (AGS).

Through adopting the agreed NHS SEL approach to risk management and board assurance, BCT believes that it has in place a sound governance structure and risk management arrangements to enable it deliver its objectives and thus serve its resident population.

The BCT systematically identifies, at all levels, those risks that could affect these objectives and takes every reasonable step to control risk. This includes a process to monitor, and if necessary improve, how risks are being managed and demonstrate how this is occurring.

BCT leadership team employs effective techniques for risk management, supported by good information systems, discusses and shares risk information amongst themselves and trains and supports all their staff to an appropriate level of expertise.

BCT also requires that the organisations and people it commissions to provide health services operate demonstrably effective risk management systems.

3.2. Purpose of risk management and board assurance

The establishment of effective risk management systems is recognised as being fundamental in ensuring good governance. Its aim is to continually improve the quality of health service commissioning through the identification, prevention, control and mitigation of risks. To do this, a systematic and consistent approach to risk management is required in BCT and across NHS SEL commissioning and other activities.

The PCTs/Care Trusts in NHS SEL have adopted the principles of the Australia/New Zealand Risk Management Standard (AS/NZS 4360:1999) in their approach to risk management. This is a generic model for identifying, prioritising and dealing with risks in any situation – at local or corporate level. It comprises definition, scope and consequence of risk. It provides an effective means of controlling and mitigating the risks associated with the delivery of commissioned services, the achievement of corporate objectives and any other aspect of health in NHS SEL.

The Joint Boards ensure that they receive robust and independent assurances on the soundness and effectiveness of the systems and processes in place for meeting its objectives and delivering appropriate outcomes. The Joint Boards therefore have overall responsibility for ensuring they have assurance that the process of risk identification, evaluation and control are effective. This is achieved through the management and application of the Joint Boards Assurance Framework. The Joint Boards Assurance Framework (JBAF) enables the NHS SEL Executive Management Team to be assured that the controls applied in the mitigation of risk are operating effectively.

3.3 Objectives

The objectives of the risk management and board assurance approach adopted by NHS SEL are:

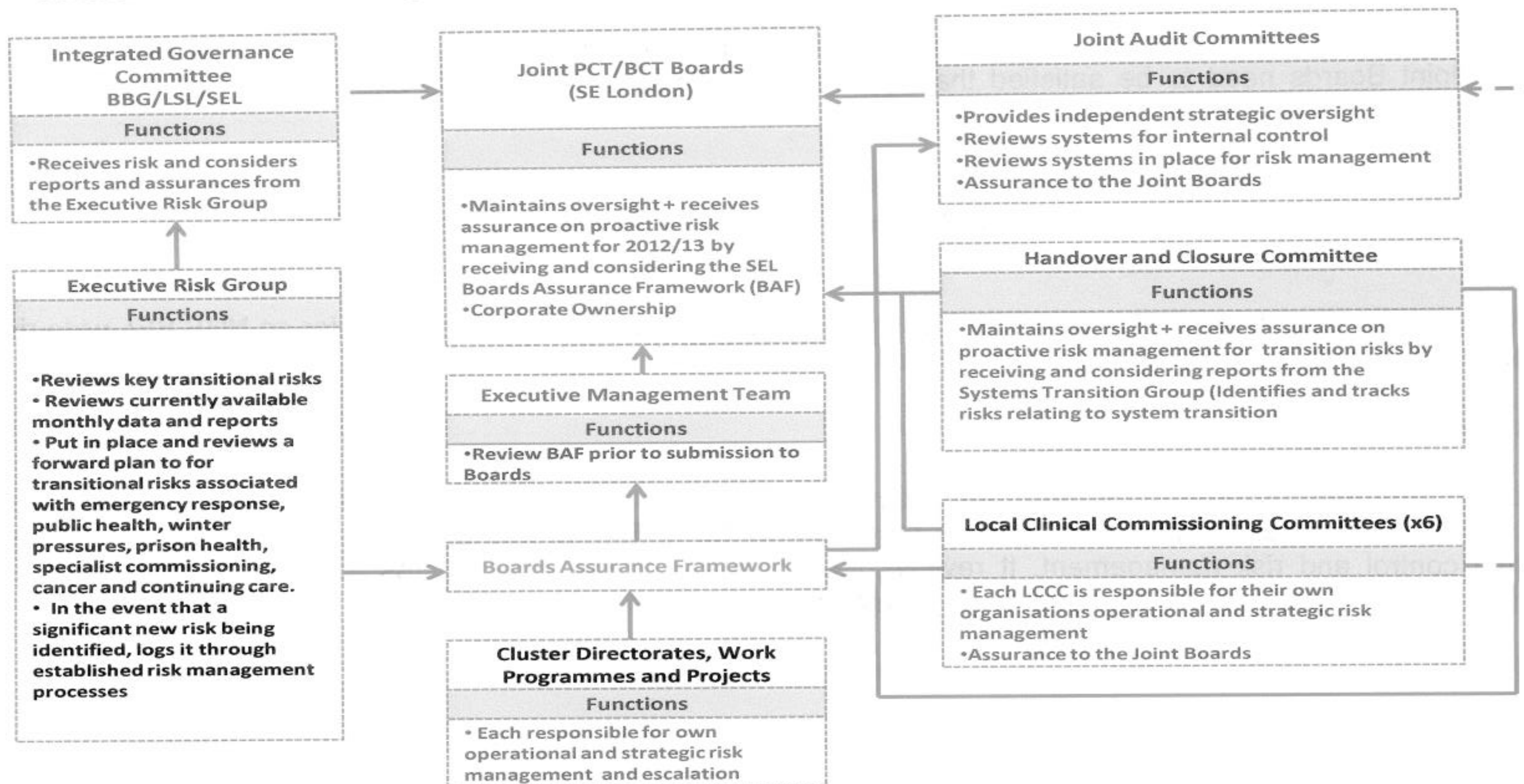
1. Ensuring compliance with all standards and regulations that apply to health care for all commissioned services;
2. Ensuring a common and integrated approach to risk management across NHS SEL;
3. Implementation and management of a robust assurance framework that addresses risks at all levels of the organisation with relevant and appropriate escalation.

3.4. Description of terms and definitions

Risk management and assurance uses a number of terms and definitions that are necessary in order to communicate its meaning, interpretations and outcomes in a common way. The description of the terms, definitions and principles that the cluster works to are set out in the joint NHS SEL Risk Management and Assurance Toolkit, a companion document to the JBAF.

3.5. The risk management structure

3.5.1 The risk management and assurance structure allows for risk to be captured, reported and managed in a consistent way across NHS SEL. It enables risks to be considered at an operational level and strategic level depending on the nature and severity of the risk as represented by an assessment of its likelihood of occurring, the potential area impacted by that risk and the consequences resulting from its potential occurrence.



The diagram above shows the high level linkages between operational risks, and NHS SEL strategic risks and the level at which oversight takes place. As with most models of risk management the structure recognises the principle of escalation between the lowest reported level of risk (department / function) to the highest reported level of risk (JBAF). This provides for a transparent, owned and accessible approach with in-built oversight.

Additional information on the above groups follows:

Joint Boards (Corporate Ownership)

The Joint Boards own the organisational objectives, risks to delivery and the assurance framework. It has identified all its key significant risks and they are being managed appropriately. Monitoring of the key risks is done via the Joint Boards Assurance Framework. The Joint Boards need to be satisfied that appropriate policies and strategies are in place and that systems are functioning effectively.

The Joint Boards satisfy themselves that operational responsibility is being discharged and that risks are mitigated to support the delivery of organisational objectives. The Joint Boards are briefed on the challenge and scrutiny exercised by its committees in order to secure additional assurance.

The Joint Boards are briefed by exception on particular local risks or borough specific considerations for an NHS SEL wide risk where this is judged to have potential for local impact at a scored level of 15 or above.

Joint Audit Committees (Assurance)

The Joint Audit Committees provide, collectively and individually, independent oversight of the governance and assurance processes on behalf of the organisations. This includes responsibility for reviewing and providing verification on the systems in place for internal control and risk management. It reviews the adequacy of the Joint Boards Assurance Framework and the structures, processes and responsibilities for identifying and managing key risks facing the Cluster.

Local Clinical Commissioning Committees (LCCC) (Assurance)

LCCC provides oversight, challenge and review of local issues, management response and interaction / dependencies with cluster activities. The LCCC also reviews locally specific risks and recommend their escalation to the JBAF in line with the principles contained within the NHS SEL Assurance Framework. The LCCC discusses risk at every meeting and considers, and acts on, its corporate risk register. This is a vital contribution to retaining local ownership and to escalating appropriate risks to the Joint Boards.

For the management and assurance of conflict of interests, Bexley Care Trust and Bexley Clinical Commissioning Group present the Conflict of interest register at regular Board / Governing Body meetings, in line with its Conflict of Interest Policy. The register is made available for public scrutiny via the website, offering transparency and openness in decision making.

Executive Management Team (Management Adoption)

Fulfils the corporate governance functions of a Risk Committee. It is responsible for co-ordinating and overseeing the development and implementation of the Policy & Strategy across the cluster. It oversees the development of the Joint Boards Assurance Framework and the maintenance of appropriate local risk registers. On an alternate monthly basis it reviews all significant risks on the JBAF prior to oversight by the Joint Boards, and new emerging risks that have escalated from the Directorates. The Committee monitors and ensures that the JBAF reflects all the key risks with particularly high residual scores and that it remains a dynamic document.

Assesses congruence and identification of issues affecting all PCTs in the SEL. Ensures all strategic risks have been identified, have been appropriately allocated and are being managed in accordance with NHS SEL policy. Makes recommendations on escalation and commonality including identification of pct specific risks (15 or above).

The Integrated Governance Committee (Management Adoption)

Considers reports from the Executive Risk Group at every meeting. This is at both macro and micro level and the depth of discussion is dependent on the matter being considered.

Executive Risk Group (Transition Risk Oversight)

In acknowledgement of the risks associated with the transitional period to March 31st 2013, the Joint Boards established an Executive Risk Group in November 2012. The Executive Risk Group was formed by bringing together senior Executive Directors, including the Nursing and Medical Director, from the Cluster and the London office of the NHS Commissioning Board. The Executive Risk Group met every fortnight and systematically reviewed key risks as the transitional arrangements unfold and as functions were handed on to the new shadow bodies. In addition to reviewing available monthly data and reports, the Executive Risk Group reviewed transitional risks associated with emergency response, public health, winter pressures, prison health, specialist commissioning, cancer and continuing care. The Executive Risk Group reported to the Integrated Governance Committee and, in the event that a significant new risk was identified through this process, was logged on the risk register.

BCT and Directorate Structures (Operational Management)

All directors have in place local risk management structures (in Bexley Care Trust (BCT) this includes aspects of capturing LCCC intelligence). All Directors and therefore their managers are responsible for; ensuring that appropriate and effective risk

management processes are in place for each department / function within their scope of responsibility; compliance to the NHS SEL approach to risk management and board assurance; bringing to the attention of their director / department lead any significant risks that have been identified where local control measures are considered to be inadequate.

3.5.2 Risk reporting and management

Risk registers are the mechanism by which identified risks and the details of the associated controls and assurances that are put in place to manage an individual risk to its agreed acceptable level are recorded.

Risk registers are used at each level of risk reporting. A core data set is required (to facilitate escalation to the JBAF which is reviewed by the Joint Boards) with local adaptation of the adopted NHS SEL approach encouraged to facilitate local management. Risks escalated to a corporate level via the JBAF will require completion of an Action Plan, thereby capturing a higher level of detail and providing the required level of additional assurance. Local processes and approaches to secure enhanced assurance are developed under the stewardship of the LCCC.

The level of risk determined to be necessary for escalation from a local or directorate risk register to the JBAF is 15 or above with impact on one of more PCTs. An action plan is completed for all risks rated as 15 or above; such reports are offered to the Boards provided that they do not contain commercially sensitive or confidential information.

3.5.3 Duties (roles & responsibilities)

A prerequisite for the effective management of risk is the need for all staff, clinicians, boards and committees to be clear on, and to fully undertake, their specific duties in respect to their roles and responsibilities within the risk management structure. These are described below.

- As signing officer delegated by the Department of Health's Accounting Officer I have taken assurance from the Accountable Officer during 2012-13 that he took overall Executive responsibility for ensuring that there is an effective risk management or assurance framework in place within the cluster, for meeting all statutory requirements, adhering to guidance issued by the Department of Health in respect of Governance. I am required to sign the Annual Governance Statement. The Accountable Officer was accountable to the Joint Boards.

- **All Directors and Managers**
  All levels of management must understand and implement the principles of the JBAF and toolkit. All Directors/Directorate

managers are responsible for: -

- Ensuring that appropriate and effective risk management processes are in place within their designated areas and scope of responsibility.
- Ensuring all staff are made aware of the risks within their work environment and of their personal responsibilities.
- Preparing specific Directorate/Departmental policies and guidelines to ensure all necessary risk assessments are carried out within their directorate/department in liaison with appropriate identified relevant advisors where necessary.
- Implementing and monitoring any identified and appropriate risk management control measures within their functions and scope of responsibility.
- Ensuring situations are addressed where significant risks have been identified and where local control measures are considered to be potentially inadequate, Directors/ Directorate managers are responsible for bringing these risks to the attention of the Executive Management Team
- Ensuring that all staff are given the necessary information and training to enable them to undertake effective risk management practices.
- Ensuring that a Risk Register is maintained for their area of responsibility.

- **All Employees** must understand the nature of risk and accept responsibility for risks associated with their area of authority. They are responsible for:-

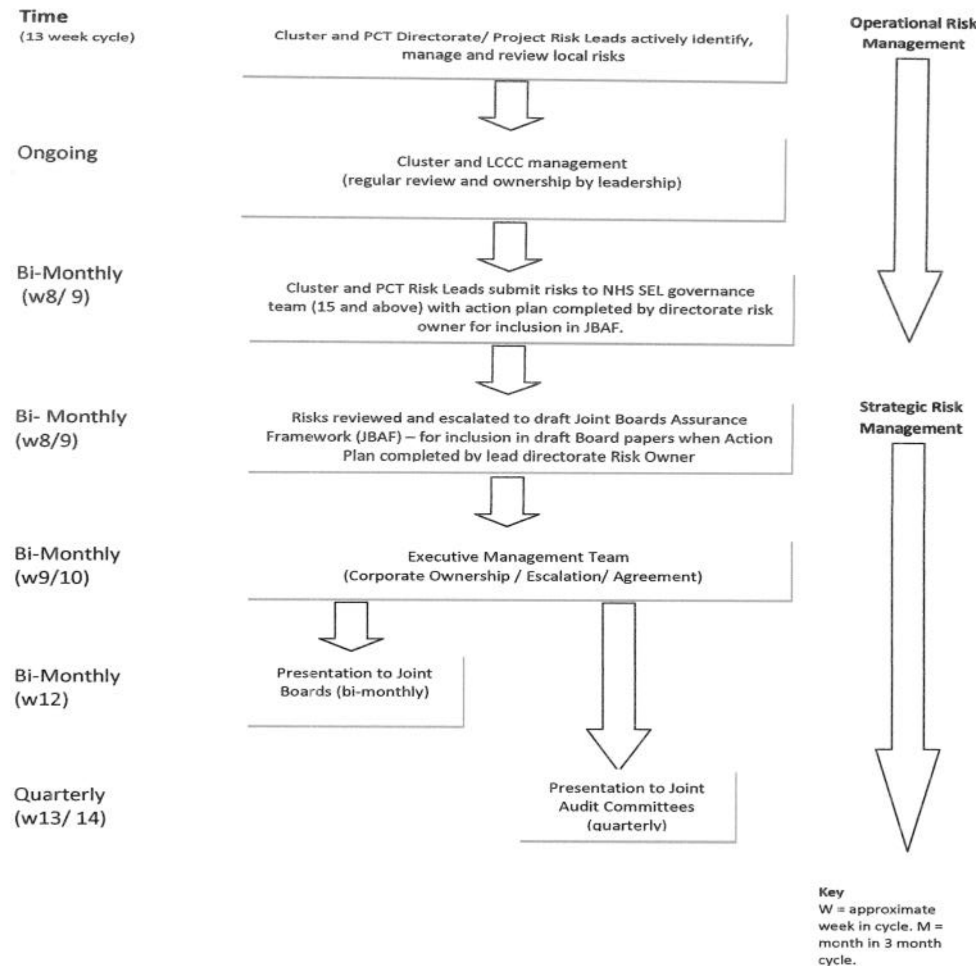
  - Reporting incidents/accidents and near misses using the agreed channels.
  - Complying with all cluster Rules, regulations, guidance and instructions to protect the health, safety and welfare of anyone affected by the Cluster's business.
  - Complying with all rules, regulations, guidance and instructions to ensure the cluster carries out its business in a safe and proper manner.

4. Risk reporting and risk ratings

4.1 Risk reporting process flow

Risks are reported and managed as shown in the diagram below. This is aligned to, and is consistent with, the operational and strategic linkages identified above and sets out the applicable timescales of the reporting process.
It illustrates the risk identification, reporting, escalations and actions at each level of risk management process.

The organisational level at which risks are managed within Directorates is set out with local determination as to application of the risk management process and reporting on outcomes. All risks recorded as strategic and those operational risks assessed to be of sufficient severity to be escalated to the JBAF (and scored above 15) require completion of action plans and is managed through the programme management process.



4.2 Risk ratings

Every identified risk has a chance of occurring therefore each risk has its own potential likelihood. Similarly if the risk were to occur then it would have its own measure of impact (also known as a consequence). It is important to recognise that risk can never be eliminated with the aim of risk management being to progressively manage risk within acceptable levels. The acceptable level of risk is known as the 'risk appetite' of a particular risk.

The NHS in SEL determines inherent, residual (current) and target risk scores (levels of risk) for every risk and these are reviewed on a regular basis for all risks.

The NHS in SEL has determined the acceptable level of organisational risk to be '9'. That is the scoring at which the PCTs/Care Trusts find a risk to be acceptable and less likely to be in need of regular monitoring or reporting. 9 is the preferred maximum, long term, target score for a risk.

Likelihood and impact are allocated a number between 1 and 5. The total risk score is the impact multiplied by the likelihood. Hence the risk score can lie between 1 (1x1) and 25 (5x5). The overall risk score determines the risk rating. This in turn determines the actions that are required to manage the particular risk.

The LCCC reviews risks above the stated tolerance threshold (10 and above). The Joint Boards, having delegated borough oversight to each LCCC, will review risks of 15 and above.

The diagram below illustrates the risk matrix scoring and consequential risk rating methodology.

Risk Matrix	Consequence				
Likelihood	Negligible	Minor	Moderate	Major	Catastrophic
Rare	1	2	3	4	5
Unlikely	2	4	6	8	10
Possible	3	6	9	12	15
Likely	4	8	12	16	20
Almost Certain	5	10	15	20	25

← TOLERANCE THRESHOLD

Key Levels of Risk	
1-3	Low Risk
4-6	Moderate Risk
8-12	Significant Risk
15-25	High Risk

4.3 Zero tolerance risks

The risk management and joint boards assurance process shows how those risks that are reported through the SEL Joint Boards BAF (JBAF) are determined. These are those high rated risks that impact all of NHS SEL PCTs and Bexley Care Trust and all those risks that are rated as being 'high'.

However there are a number of areas where the boards might benefit from being aware of an existing risk, regardless of risk rating at any particular point in time. These risks are referred to as 'zero tolerance' risks and are noted on the JBAF. Recommendations for classification of zero based risks come from directors and are assessed by the Executive Management Team. NHS SEL has identified five zero tolerance risks, Safeguarding, Emergency planning, Staff Retention; Conflicts of Interest and reputation risk.

Where a borough specific risk is reported by exception to the Boards and this is aligned but scored more highly (15 or above) than an identified Joint Boards level risk then the latter risk will be reported as a zero tolerance risk in order to ensure that the Boards have sufficient context and access to all relevant information on the issue.

5. Independent assurance

5.1 External audit

During the reporting year 2012-13 the External Audit provided assurance in line with the agreed audit plan.

5. 2 Internal audit

Internal audit reviews the process for the maintenance and delivery of the JBAF and provides the assurance that it meets the requirements of the Department of Health. Internal audit also reviews other risk areas in line with an agreed annual audit plan and reports its findings to the audit committee.

5.3 NHS Litigation Authority (NHSLA)

The NHSLA perform an independent assessment against risk management standards, in order to establish the level of discount the NHS SEL receives in relation to its indemnity contribution schemes. No assessment was carried out during 2012/13.

6. Reviews and updates

The approach Joint Boards adopt to managing risk and gaining assurance is/was reviewed annually by both the Joint Audit Committees who will report to the Joint Boards upon its findings. An additional review relating to areas of best practice and practical application will be undertaken by the Governance team.

7. New risks identified in the year 2012/13

7.1 The risks in the following table scored 15 or above (High or Red rated risks) and appeared for the first time on the Joint Boards Assurance Framework during 2012/13. The risks were accepted by the Joint Boards at their bi-monthly meeting on behalf of the relevant PCT or PCTs.

ID	Work Stream	Date Raised	Risk Category	Risk Description	Initial Risk Score	Still on JBAF @ 31/03/13	Risk Score @ 31/3/13	PCT/ Care Trusts affected by Risk
FB13	QIPP	25/04/2012	Financial	There is a risk that over performance and data quality with providers remains poor and unchallenged caused by insufficient capacity and lack of systems and if demand management is not robustly monitored and further QIPP schemes developed to mitigate cost pressures, the Care Trust will not meet statutory break even duty leading to failure to obtain CCG authorisation. This risk is further worsened by the potential lack of capacity within procurement that may delay the implementation of QIPP schemes. On 30.05.12 risk Op2 from cluster was transferred and incorporated into this risk.	16	No deescalated from JBAF or closed		Bexley Care Trust
CG3	Governance	28/02/2013	Quality and Patient Safety	The triangulation of information both soft and hard data suggests that there are a number quality and safety issues at the QEH. Until evidence of assurance proves otherwise, this has to be taken seriously by	15	Yes	15	Bexley Care Trust

				both commissioners and the provider.				
ICT18	ICT	27/04/2012	Information Management and Technology	There is a risk that the amount of change to happen in 2012/13 due to changes in the NHS such as the closure of PCTs will lead to an undeliverable ICT workplan, leading to some change requirements not being met	**16**	No: deescalated from JBAF or closed		All PCTs/ Care Trust
E25	Governance (Approval)	01/05/2012	Governance	There is a risk that lack of clarity about the future of the Capital Strategy Group caused by internal review of corporate governance arrangements will lead to delays in reaching decisions on business cases for capital schemes, disposals etc	**15**	No: deescalated from JBAF or closed		All PCTs/ Care Trust
ICT25	ICT	18/05/2012	Information Management and Technology	There is a risk that the main data centre for the core ICT network covering LSLG is housed in Lower Marsh, whose lease ends on 28/9/12, leading to a significant clinical and financial risk if the lease is not extended	**20**	No: deescalated from JBAF or closed		All PCTs/ Care Trust
ICT28 (i)	ICT	02/07/2012	Information Management and Technology	There is a risk that proposed structures for the South London Commissioning Support Service are not fit for purpose and reduce ICT resources and capability at a time when increased resources are needed to meet organisational changes within South London	**20**	No: deescalated from JBAF or closed		All PCTs/ Care Trust

ICT28 (ii)	ICT	02/07/2012	Information Management and Technology	There is a risk that a number of staff will not have posts within SLCSS as of 01/10/12, leading to low morale, unclear line management and a lack of customer focus, leading to an increased risk of not meeting the needs of the business during the second half of 2012/13	16	No: deescalated from JBAF or closed		All PCTs/ Care Trust
IGR42	IG	19/08/2012	Legal & Compliance	There is a risk that successor organisations (the CSU)will not be set up to deal effectively or efficiently with information governance and information management caused by the levels of resource available and the complexity, pace and lack of clarity around transition leading to a failure to become authorised and embed efficient business processes	16	No: deescalated from JBAF or closed		All PCTs/ Care Trust
IGR50	IG	14/01/2013	Legal & Compliance	The NHS Commissioning Board is a new national organisation and as such it is likely that records management processes are not yet fully developed or embedded. Therefore there is a risk that records transferred to the NHS CB may not be fully managed in keeping with NHS requirements in the short term. Records cannot be transferred until assurances are received.	16	Yes	16	All PCTs/ Care Trust

Bexley CCG Risk No. FB13 - The CCG has operated a Programme Management Office gateway process for the validation, approval and monitoring of all QIPP schemes throughout 2012/13. A RAG Rating procedure is now in place to ensure appropriate governance around the financial value to be included in plans, with membership consisting of internal and external stakeholders.

QIPP has been reported internally to the Finance Working Group and the Executive Management Committee. Star Chamber

meetings are now held monthly to aid in the delivery of schemes experiencing blockages or problems with delivery. High level performance has also been included in the finance report at each Clinical Cabinet meeting. Regular one to one meetings with project managers are now being held to review project progress and update RAG ratings. Risks & mitigating actions are identified and taken forward for each project. In addition, monitoring has been collected by the South East London cluster to include in the monthly Financial Information Monitoring forms (FIMS) submitted to NHS London and the Department of Health, and has been reviewed at bi-monthly stocktake meetings with the cluster.

A KPMG audit on "QIPP Management" conducted during November & December 2012 noted within the report's executive summary "Areas of good practice" where they commended the governance process at Bexley.

"Bexley have an extensive and well established PMO function, where all stakeholder ideas are encouraged to be discussed, in order to capture potential savings for the aspirant CCG. The function includes a clear gateway process for ideas generated, a viability assessment questionnaire, and well established templates for business cases, project initiation documents, implementation and monitoring". KPMG

In 2012/13 the CCG achieved 95% of its total QIPP savings.

A map of Risks for Bexley is presented below.

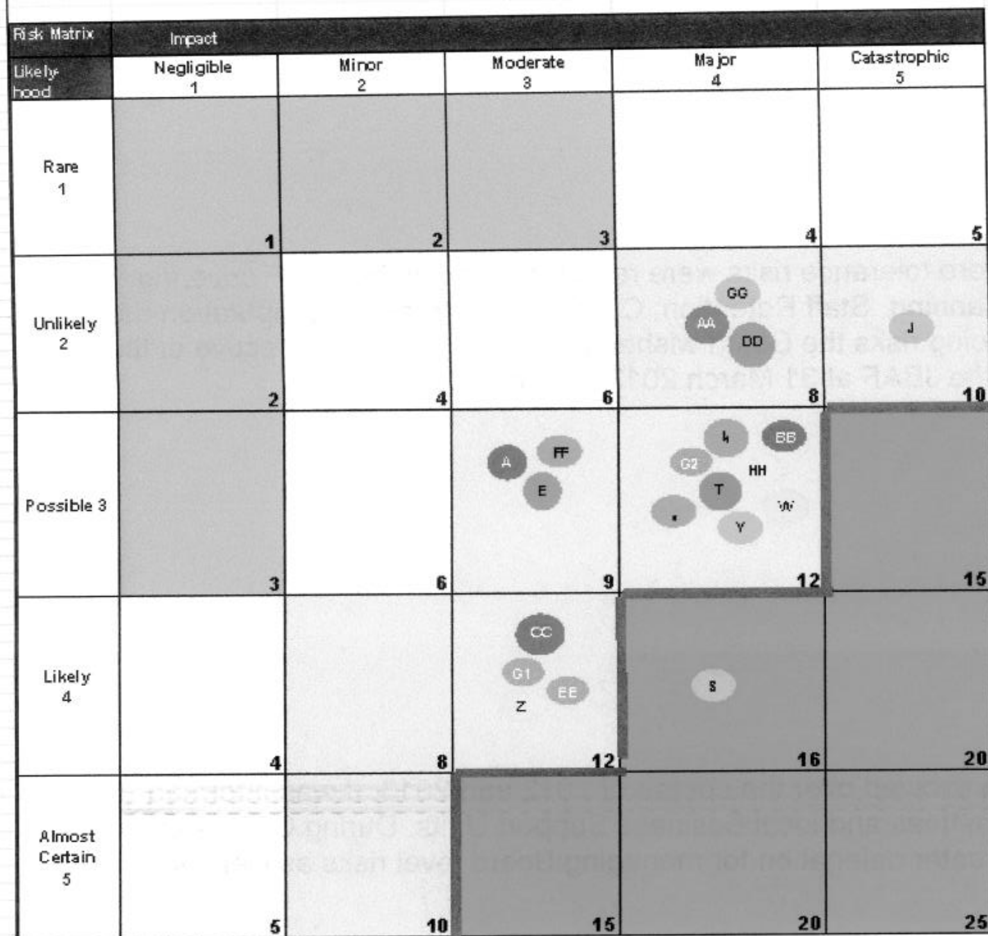
Bexley CHC Claims and Risk Assessment

Bexley undertook a detailed due diligence in relation to the transfer schemes.
The Care Trust received a total of 288 for Continuing Health Care following the Department of Health's announcement in March 2012. These claims have been assessed thro through the year and a financial provision has been made based on estimates of the potential financial exposure. Please see section 10 bullet point 9 (page33).

It has been identified that there is a risk that the transfer of balances to the CCG and other organisations following completion of the Annual Accounts will be insufficient to pay outstanding liabilities (excluding CHC), which may result in failure to meet financial break even in 2014/15. Actions have been identified and the risk is closely managed and actively reported via the Finance Working Group.

This has been recorded on the local Risk Register in line with the controls and actions that are in place.
A map of Risks for Bexley is presented below.

Bexley Assurance Framework - Heat Map of Risks at the 31 March 2013



	Risk Description
A	No budget for total health / polysystems implementation
E	LA partnerships
G1	Higher cost placements for children
G2	Anti and neo-natal screening SIs
h	Remuneration process
J	Safeguarding children (organisation change)
S	Data Quality and Challenge
T	CCG Authorisation
W	Management of Controlled Drugs
.	Capacity of Finance Team
Y	Management of Financial Pressures
Z	Staffing cost pressures
AA	Capacity of Finance Team - CSO/Development Agenda
BB	Capacity of Senior Finance Team
CC	Breaking Even/Achieving 1% surplus
DD	Adult Safeguarding
EE	Babies & Children with complex needs - cost pressure
FF	Mental Health and LD Safeguarding
GG	Pathways of Care - Child Safeguarding
HH	Quality of care by providers

7.2 A summary of the above RED risks still on the JBAF at March 2013 by work stream is given below:

Bexley - Work Stream	Red
Acute Commissioning/ Contracting	0

Continuing Care	0
Finance	0
Information Governance	0
Governance	1
QIPP	0
Safeguarding Children	0
Total	1

In addition to the Zero tolerance risks detailed above, other zero tolerance risks were reported through the JBAF covering the following areas: Adult and Child Safeguarding, Emergency planning, Staff Retention; Conflicts of Interest and reputation risk. These additional zero tolerance risks scored under 15 but were ongoing risks the Board wished to retain sight of irrespective of their current risk score. A summary of the zero tolerance risks on the JBAF at 31 March 2013 is given below

Zero Tolerance Risk	NHS Cluster	Bexley
Adult Safeguarding		✓
Child Safeguarding		✓
Emergency planning	✓	✓
Staff Retention	✓	
Conflicts of Interest		
Reputation risk	✓	

The common risk framework used across South East London evolved over the course of 2012 and 2013. It was informed by analysis and consideration by the Joint Boards, Boards Committees and local Business Support Units. During CCG preparation in 2012 and 2013 the Clinical Commissioning Groups gained greater delegation for managing Board level risks as well as their own local risks.

The risks listed above are managed by the process described in this document.

Adult Safeguarding – In Bexley, although the Safeguarding policy and procedures had been developed the appointment for the Safeguarding lead was underway. The recruitment has been completed and the lead for Safeguarding has been appointed.

Children Safeguarding – In Bexley, Safeguarding Children procedures and Processes have been developed. The Risk remains

on the register as if there are any failures within the existing controls this could lead to unintended outcomes.
Emergency Planning – There is an inherit risk due to uncertainty and clarity around the Emergency Planning Function. However, Training is in place, Joint working with providers and development of surge plans are the controls in place, mitigating the risk faced. Business Continuity Strategy and Plans are being developed and assurance is sought from all providers ensuring Business Continuity Plans have been developed locally.

There are other risks that are managed at PCT/Care Trust and Cluster Directorate level but have not warranted escalation to the Joint Boards.

8. Assurance

In October and November 2012 Internal Audit carried out a review of the BAF and Risk Management processes in each of the six Primary Care and Care Trusts in South East London. Summary of the findings and recommendation along with the status on completion for Bexley is detailed below.

Summary of Findings

The internal Audit carried out for SEL organisations included Bexley CCG. The report concluded that the risk management structures and controls put in place by the CCG) require improvement. The report stated that BCCG has adopted the recommendations raised in our prior review, but there is still scope for improvement in the controls in place for managing risk specifically around ensuring that forward action plans are SMART so that governance committees can track these translating in to new assurances and controls to reduce residual risk ratings. The report also raised a further series of recommendations as part of this year's review. The report recommended that BCCG need to ensure that they have documented and agreed a formal risk appetite statement before the cluster and its Joint committees demise over the coming weeks.

Summarised below is the number of recommendations Highlighted by the Internal Audit report from KPMG.

	High (1)	Medium (2)	Low (3)	Total
Belxey			2	2

Risk	Recommendation Area	Status	Date Completion / Completed

	SMART actions Action plans stated in risk registers in a number of cases do not give adequate assurance on how the risk is being mitigated. There is no explicit requirement or guidance in the risk register for actions to be SMART. It should be made clear within risk management strategies that actions should be SMART and the quality of actions should be reviewed by the governance lead when updates are made to the Corporate Risk Register/Assurance Framework.	On-going	June 2013
	Reflection of risk appetite within actions in the risk register All risk registers display the decision to accept or mitigate the risk in a separate column in the risk register and that residual and target risk scores reflect the decision to mitigate or accept the risk. The governance lead checks that all entries have been completed prior to the escalation of risks into the corporate risk register.	Completed Column added to the Risk Register and Risk Management Framework was approved on 25 Oct 2012. All risks now display action with Risk appetite.	Feb 2013

9. Summary of lapses of data security, including any that were reported to the information Commissioner

The key items of data security that were reported into the Bexley Care Trust incident reporting framework and/or the ICP are as

follows:

- EMIS Server upgrade resulted in server with patient data being left inappropriately against the practice rubbish bin, which subsequently got taken off by the local councils rubbish truck and crushed as part of their waste process. Reported to ICO with full investigation report. No ongoing action recommended.
- Caldicott Guardian at the Practice reported an IG breach involving the Practice Manager making covert video recording within the workplace without consent and knowledge of those being recorded. This incident was reported to the cluster SIRO and was investigated and heard by the cluster with recommendations given to practice.

10. Significant Issues

This section sets out: first, an overview of the major challenges that we expect **as Bexley** Clinical Commissioning Group to face.

Challenges during 2013/14

During 2013/14 CCGs face a number of significant challenges as they deliver against the NHS Operating framework. From a governance perspective these challenges fall into three areas: **building on the transition**; **doing things differently**, and **improving quality** of local healthcare services.

1. Delivering the transition

2013/14 will be a challenging year for Bexley CCG, building on the success of its shadow running which commenced on 1 October 2012. We recognise the risks associated with the transition to new commissioning arrangements. We have robust plans in place supported by governance arrangements that will enable us to address the ongoing risks associated with transition whilst continuing to fulfill our statutory duty in 2013/14 of delivering the health and wellbeing needs of our local population.

2. Doing things differently

A significant amount of transformational change is needed across the local health economy in South East London and locally in Bexley CCG. We would continue to deliver service redesign schemes to maximise the benefits of our local integrated community Trust (Oxleas) and acute Trust (South London Health Care Trust).

BCT is working with other South East London clinical commissioners to deliver the NHS single number '111' programme. There is a closely managed process in place to deliver the 111 service in South East London, including the mitigation of financial and other risks associated with the Project. A 111 Project Board has been established and meets regularly.

3. Improving quality

We have set an ambitious productivity improvement targets for our health economy. Through our governance structures and processes we are monitoring and assuring execution of our plans on an ongoing basis, to ensure that we make savings without compromising the ongoing improvement of care quality, including outcomes across cancer, Referral to Treatment, A&E and waiting times.

The Olympics and Paralympics were a great success in London during the summer of 2012. The local NHS maintained "business as usual" despite the resulting operational pressures.

In relation to the recommendations identified in relation to Croydon PCT, SEL cluster reviewed the recommendations identified in the report following the investigation into Croydon PCT's financial position to ensure that a similar situation would not arise in the South East London PCTs. The action plan was reported to the Bexley Clinical Cabinet.

With regards to Francis report, Bexley has considered all the actions and recommendations have been considered and a detailed report was considered by the Governing Body, papers available via the web-site.

Specific issues identified during 2012/13

We continue to work with our internal auditors to identify areas where our systems and processes for governance and internal control can be further strengthened. The work of Internal Audit during 2012/13 resulted in twelve high priority recommendations where improvements could be made to internal control systems and processes. These recommendations have been agreed by the Care Trust Management and the resultant actions have been taken, or are in the process of being taken.

These covered:

Topic	NHS SEL Cluster	Bexley
Conflicts of Interest	1	
HR Staff Records	3	
General IT Controls		2

TSA Recommendations

A number of solutions have been tried over many years to overcome the challenges faced by the South London Healthcare NHS

Trust and its predecessor organisations in south east London. However, none have delivered the scale of change required to secure clinically and financially sustainable services for the long-term for local people.

On 16 July 2012 a Trust Special Administrator (TSA) was appointed to the Trust by the Secretary of State for Health under the Regime for Unsustainable NHS Providers (UPR). The Trust Special Administrator's final report outlining recommendations to secure sustainable services for those served by South London Healthcare NHS Trust and the wider NHS in south east London was published by the Secretary of State for Health on Tuesday, 8 January 2013 and he announced his decision on Thursday 31 January 2013

Following consultation with staff and members of the public, the Governing Body of Bexley has considered the recommendations from TSA report "Securing sustainable NHS services: the Trust Special Administrator's report on South London Healthcare NHS Trust and the NHS in south east London ". Bexley's local response and challenges are outlined below.

1. **The pace and scale of proposed changes present a significant challenge in terms of managing the complexity and timing of safe implementation. This will require shared leadership, high levels of co-ordination and significant additional change management capability within South East London. This will need to be appropriately resourced as part of the additional transitional resource requirements.**

2. **There will need to be a credible implementation plan which effectively bridges the conclusion of the TSA process into the embedding of the changes in practice.**

   There are a number of practical aspects of this which include:-

   - a published and transparent efficiency plan for the successor hospitals to SLHT, which is agreed as part of the 2013/14 contracting round so that we can all see how the recommendations from the TSA on productivity and efficiency will be delivered.

   - The implications of the Community Based Care strategy should be reflected into a clear and phased capacity reduction

plan alongside a jointly agreed double running costs/bridging plan. - Handling and bridging the projected, albeit reducing, acute deficit that will play out between 2013/14 and the end of the reconfiguration of the system. We think there should be consideration of this debt as well as the historic debt up to the point of full implementation of the full, new system. - commissioners recognise the need to start the 2013/14 contracting round with clear and jointly agreed assumptions around the handling of in year 2102/13 over-performance, contract baselines and ensuring that all QIPP assumptions align . - creating a clear workforce plan. - agreeing and publishing common standards for key services.

3. **We have set out in our commissioning intentions that outpatients and diagnostics will continue on the QMS site and that the clinical model that is agreed will support our "hub" approach.**

   We would like to ensure that we can support the maximum number of Bexley residents who choose to, to have their diagnostic and outpatient work at QMS; likewise for day surgery/procedures – and that residents should only have to go to another hospital for overnight care, A&E services, or for genuinely specialised outpatient/day interventions. We note that the TSA are recommending Dartford and Gravesham NHS Trust be a key player in the outpatient service during the transition period, prior to full procurement. We have already been working closely with D&G and Oxleas and intend to continue to work closely with all providers to ensure that the Bexley QMS Campus model offers patients a first class integrated and affordable health facility, whilst ensuring we can still deliver patient choice.

4. **The pricing of the QMH site rents and "back-up" services such as diagnostics and non-clinical support services needs to be transparent.**

   We support Oxleas assuming the site landlord role and will as commissioners are expecting the tariffs and benchmarks for their charges to be explicit and comparably fair to all providers.

5. **Proceeds from the sale of land should be used locally for patient care**

   There is a strong commitment to a new model of service in Bexley, securing land sales' investment for the improvement of care locally, particularly through the transition and supporting the transition for QMS is supported by the governing body and would give public confidence.

6. **Workforce development**

The CCG would recommend that as part of the implementation plan there is a clear workforce plan that sets out the

requirements for workforce numbers and skills required. The new Local Education and Training Board will have a key role to play in this, as well as local Higher and Further Education Institutions. Through the Community Based Care Strategy, it has been recognised that there needs to be a focus on primary care capacity, especially GPs, required for the future. There is a need to shape and agree a new operating model for General Practice, underpinned by a financial and capacity development plan and the support of commissioners in the National Commissioning Board and the local CCGs .

7. Lewisham ENT (A&E) Service

This service is hugely valued by local GPs and we expect that efforts will be made to make sure that the capacity and expertise of this service is not lost in the new arrangements.

8. Access and Capacity

The Governing Body, GPs and Patient Council all believe that effective capacity planning will be key to the success of new models, particularly to urgent and unscheduled care. We would recommend that there is clear understanding of shifts in activity from Lewisham A&E, that there are effective thresholds for UCCs to handle the right intensity of work and that LAS capacity is understood as part of the implementation plan.

9. NHS Continuing Care

In March 2012 the Department of Health announced deadlines for individuals or their representatives to notify the relevant PCT if they believe there was a period of care between 1st April 2004 and 31st March 2012 where there is evidence that the individual should have been assessed for eligibility for NHS continuing healthcare (NHS CHC). This only applies to new cases i.e. where, the individual has not previously been assessed for NHS CHC during the identified period. The first deadline was the 30th September 2012 relating to claims between 1st April 2004 to 31st March 2011. The second deadline was 31st March 2013 relating to the period from 1st April 2011 to 31st March 2012. The PCT received a total of 288 claims representing a significant financial risk to the organisation. The process of assessing the impact of these claims has been ongoing through the year and a financial provision has been made based on estimates of the potential financial exposure using the latest information available at the time.

11. Review of the effectiveness of risk management and internal control

The Department of Health's Accounting Officer has designated the role of signing officer for the final accounts and governance statement. In fulfilling this role I have taken assurance from the Accountable Officer on the effectiveness of the system of internal control and risk management. The review of the effectiveness of the system of internal control was informed by the work of the internal auditors, executive managers and clinical leads who had responsibility for the development and maintenance of the internal control framework. This review was also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of the review of the effectiveness of the system of internal control by the Joint Boards, the Joint Audit Committee as well as the Department of Health Audit Sub Committee and the Integrated Governance Committee and action to address weaknesses.

This review was further informed and supported by the work of the Joint Boards, the Joint Audit Committees and the LCCCs. The Joint Boards, Joint Audit Committees and the LCCCs reviewed the Joint Boards Assurance Framework at each meeting during the year.

Executive managers within the organisation who had responsibility for the development and maintenance of the system of internal control provided assurance. The JBAF itself provided evidence that the effectiveness of controls that managed the risks to the organisation achieving its principal objectives had been reviewed. The review was also informed by the final report of external and internal auditors, and internal management reports and other key reports.

The Head of Internal Audit Opinion for 2012/13 is that substantial assurance can be given that there is generally a sound system of internal control on key financial and management processes. These are designed to meet the Care Trust objectives, and controls are generally being applied consistently.

However, internal audit have identified specific areas where high risk recommendations required action to ensure that the Care Trust's strategic objectives were met and the systems of internal control remained sufficiently robust to mitigate critical financial, operational and governance risks.

I have been satisfied that the governance statement incorporates a full description of the board's committee structure and performance together with appropriate reference to performance against national priorities set out in the NHS Operating Framework 2012/13. I have been given assurance that the Governance Statement has taken appropriate account of the guidance issued by the Department of Health.

I believe that the above, combined with the outputs of the Governance Framework give me substantial assurance that the risk management processes and systems of internal control put in place are operating effectively and that the statement has been prepared in accordance with the Department of Health Guidance.

Department of Health Designated Signing Officer
Carl Vincent – Director of Provider Finance and Finance Transition

Signature: **Date :** 31/5/13